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ABSTRACT

The ninth volume in a 10-volume report on the historical development (1966-1973) of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this report presents information on the Portland Area Office. Included in this document are: (1) The Context (early history of the Oregon Territory, geography and tribal characteristics, population of American Indians served by IHS, and Area Office and transportation links); (2) Mental Health Activities Prior to 1969 (University of Washington Medical School at Yakima and Neah Bay and Port Hall Suicide Prevention Program); (3) First Full Time Mental Health Team in 1969 (staff; consultation patterns; objectives; and special projects such as foster homes, peptic ulcer study of Makah tribe, alcohol abuse treatment planning, etc.); (4) 1970-72 Program Development (staff and special programs/projects including Chemawa Boarding School, Warm Springs Mental Health and Alcohol Project, etc.); (5) 1973-74 Program Developments (staffing patterns; staff activity; selected Service Unit Programs including Northwest Coastal tribes, Rocky Mountain tribes, Great Basin reservations, and Columbia Plateau reservations); (6) Warm Springs: Health Program (Warm Springs reservation, Alcohol Abuse Program, Children's Group Home, Multiple Problem Family Project, major mental illness, coordination of total program, success characteristics, and aides); (7) Summary (achievements and problems). (JC)

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Vol. 9, Set 1

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PORTLAND AREA

Service Networks
and
Patterns of Utilization

Mental Health Programs I.H.S.

Partial fulfillment of
Contract No. 110-73-342

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PORTLAND AREA

MENTAL HEALTH PROGRAMS
OF THE
INDIAN HEALTH SERVICE
1966-1973

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Service

Prepared by

Carolyn L. Attneave, Ph.D. and Morton Beiser, M.D.

Department of Behavioral Sciences, Harvard School of Public Health

This material has been prepared in connection with an initial evaluation contract to appraise IHS Mental Health Programs seven years after their formal introduction into the system in 1966. (IHS Contract No. HSM 110-73-342) As originally conceived the report was to be based upon a sampling of about three programs in the eight major Areas: One outstanding, one average, and one new or otherwise struggling. Administratively, Area Chiefs of Mental Health and their staffs found it impossible to participate in such a selection, and instead the staff has been required to inform themselves about over 90 programs and present their findings about each as objectively as possible.

The chapter for each Area follows a standard arrangement of information, varying in detail as the Area development indicates. There is first a description of the geographic and cultural context within which Area programs and Service Units work. Secondly, there is a reporting of the historical roots of mental health activities in the Area as far back in time as it has been possible to find evidence of them. In some instances this is coincidental with the formation of IHS in 1955, but in most it appears a few years before introduction of formal budgetted mental health staff. The latter sections of the report develop in chronological order (usually in two year segments) the personnel and activity of the Mental Health programs for the Area. Unique and special programs are presented in detail. Finally, an overview and summary of achievements and problems yet to be resolved concludes the description of the Area, which was completed as of the spring of 1973.

The concluding chapter of the report and the extensive sections on inpatient programs will be of interest to all Areas. It is also hoped that staff in one Area will find it of value to see what other Areas have done or are facing in the way of similar problems. and differing ones. However, when need arises, or interest is focused on only one Area, it is hoped that that chapter may be used as an independent unit.

PORTLAND AREA INDIAN HEALTH SERVICES MENTAL HEALTH PROGRAMS

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PORTLAND AREA PERSONNEL LIST

MENTAL HEALTH BRANCH
SOCIAL SERVICE BRANCH

Name	Branch	Dates of employment	Position
CHEMAWA			
Tom Keast	SS	8/1/71—6/1/72	Social Worker
Al Folz	SS	12/10/72—6/10/74	Social Worker
COLVILLE			
Jo Marcelley	MH	11/23/70—	MHW
Nancy Melise	SS	8/6/72—	MSW
Caroline Sellars	MH	8/8/73—	Secretary
Ted Kammers	SS	12/27/70—5/28/72	MSW
Lena Wilson	MH	12/12/71—6/10/73	Secretary
FORT HALL			
Robert Pepper	MH	4/29/73—	MSW
Roserine Martin	MH	7/23/72—	MHW
Eula Peyope	MH	7/23/72—	MHW
John Bopp	SS	12/1/66—4/30/72	MSW
Thelma Waller	MH	4/6/69—1/19/73	MSW
LUMMI			
Vendean Washington	MH	7/23/72—	MHW
Jay Navarro	MH	5/12/74—	MH Psychologist
NEAH BAY			
Paula Hope	MH	1/20/74	MHW
Donna Sones Grosz	MH	11/1/70—8/30/73	MHW
NORTHERN IDAHO			
Tom Keast	MH	6/1/72—	MSW
Bob Francis	MH	8/6/72—	MHW
TAKHOLAH			
Ted Kammers	MH	5/28/72—	MSW
UMATILLA			
Terry Farrow*	MH	11/29/70—	MHW
Clarence Cowapoo	MH	10/28/73—	MHW

*On long-term training--Portland State University

V

Portland Area Personnel List continued

Name	Branch	Dates of Employment	Position
WELLPINIT			
Chris Sijohn	MH	3/17/74--	MHW
WESTERN WASHINGTON			
John Bopp	MH	4/30/72--	MSW
YAKIMA			
Richard Gaulke	SS	12/1/66—	MSW
Fred Martin	MH	3/13/72—	MHW
Pete Olney	MH	5/12/74—	MHW
Francis Gopher	MH	12/23/73—	Secretary
Dolly Tahsequah	MH	5/10/71—12/23/73	Secretary
PORTLAND AREA OFFICE			
Billee VonFumetti	MH	7/1/70—(chief in 73)	RN--Chief, MH
Al Folz	SS	6/10/74—	MSW--Chief, SS
Dolores Gregory M.D.	MH	9/28/73—	Psychiatrist
Carolyn Whitney	MH	9/22/69--	Program Asst.
James H. Shore M.D.	MH	7/14/69—8/29/73(chief)	Psychiatrist
Ashley Foster Ph.D.	MH	8/24/69—11/1/71	Psychologist
Rosalie Howard Ph.D.	MH	10/31/71—5/4/73	Psychologist

PORTLAND AREA IHS MENTAL HEALTH PROGRAMS

1966-1973

I. THE CONTEXT

A. Early History of the Oregon Territory

The Portland Area of IHS has 12 Service Units, located in three states: Oregon, Washington and Idaho. This three state Area was known as the Oregon Territory, and is diagonally bisected by the Oregon trail of 1805. (US 80 and 15). In the 1600 and 1700's Spanish, Russian, English and American sea Captains had touched the Coast. However until about 1824 the entire area was claimed by Russia as part of her holdings centralized in Alaska but extending at one time into Northern California. In 1823 and 24 as a result of treaties between England and the US, Russia relinquished Czarist claims to any territory south of the Alaska panhandle at 54° degrees 40 minutes N. Until 1846 the entire Oregon Territory was jointly claimed and settled by both the US and Canada. A final treaty negotiated under President Polk fixed the 49th parallel as the Canadian Southern Boundary from the Great Lakes to the coast, but ceded Vancouver Island to the British. The 42nd parallel divided the Oregon Territory from California.

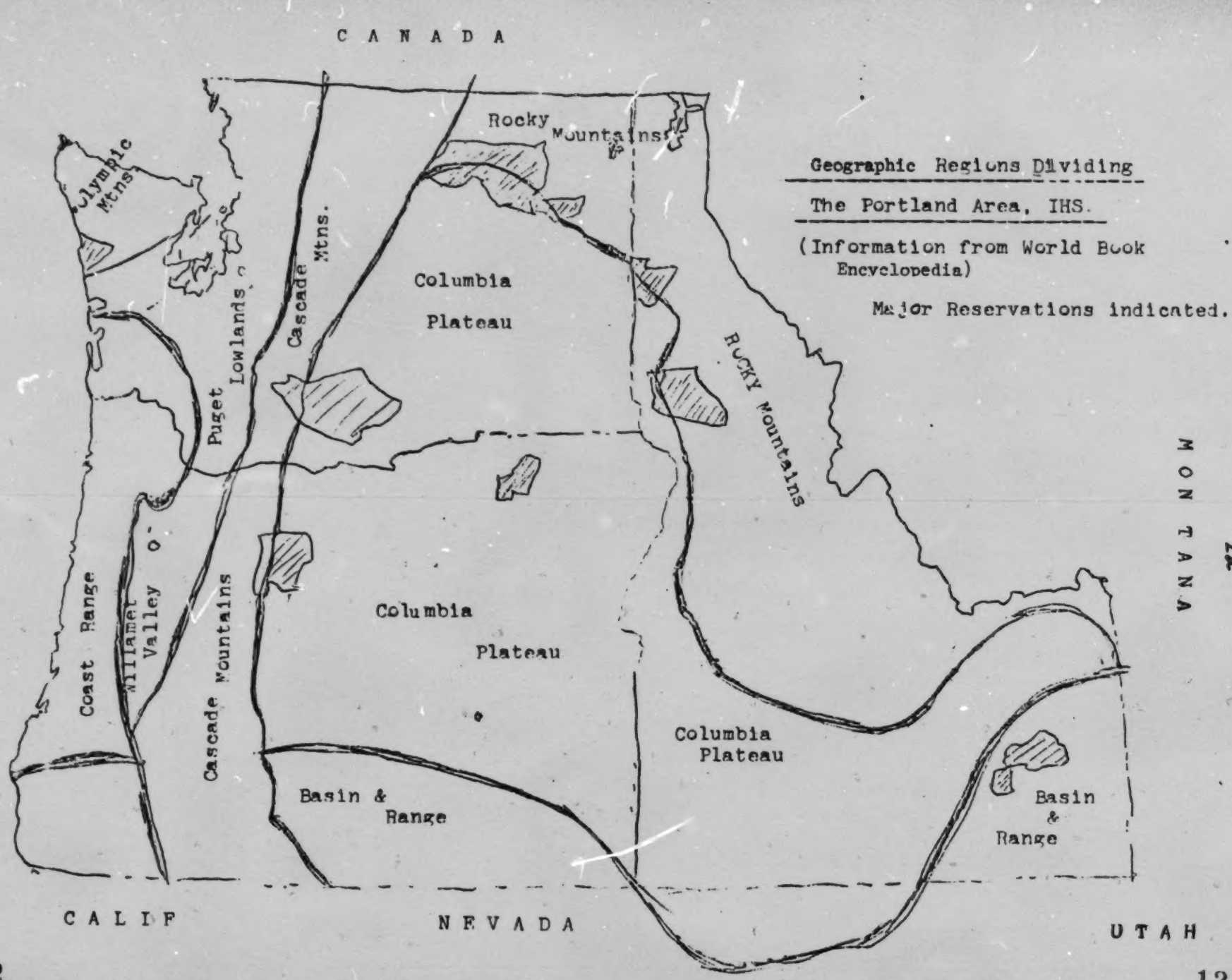
The earliest American settlement of this territory began around 1811 with Jacob Astor's establishment of a port and trading center at Astoria on the Oregon coast. A rival Hudson's Bay Co. Canadian trading post at Vancouver, on the North Bank of the Columbia embodied British claims, and control of the fur trade balanced, sometimes precariously, between the two nations.

By the 1830's American Missionaries began the first permanent settlements in the Willamette valley and along the Oregon trail near what is now Walla Walla Washington. These settlements became waystations for westward emigrants, and provoked clashes with the tribes of the interior and some locally prominent massacres in retaliation.

These uprisings however did not cause permanent difficulties, and the first state formed out of the Territory was Oregon, admitted to the Union on Valentine's Day 1859. The State of Washington developed more slowly, and was admitted 30 years later on November 11, 1889. The remaining portion of Oregon Territory became the state of Idaho in 1899, and some of its irregular shape is said to be due to the earlier definition of states on either side.

B. Geography and Tribal Characteristics

Although not ordinarily considered a unit today, there are geographic as well as historic reasons for forming an Area from these three states. They share a number of geologic regions, especially the Mountain ranges along their Eastern and Western boundaries, and the Columbia Plateau lying between. Along the Pacific Coast are the rolling hills of the Coast range, punctuated by older higher peaks of volcanic origin. These are most noticeable where the Klamath Mountains of the southern Oregon Coast lead abruptly into cliffs at the Coast line, and merge with the Cascades inland. The Olympics of the northern Washington Peninsula are dramatic snowcapped peaks, which might be considered part of the Cascades. They still retain most of their wilderness and primitive characteristics. A narrow coastal plain creates a margin in the Puget Sound area that surrounds the Olympics.



Geographic Regions Dividing The Portland Area, IHS.

(Information from World Book Encyclopedia)

Major Reservations indicated.

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13

The Puget Sound and its accompanying lowlands were scoured out by glaciers, then filled in by sand dunes and marshes, as the glaciers retreated northwards. Today these Puget Lowlands remain low, marshy and very fertile. The islands and inlets of Puget Sound afford many natural harbors, some of which have been developed by American industry and the armed forces at Tacoma, Bremerton Navy Yards, Port Angeles, Bellingham and Seattle. Others are used as recreation areas by many urban dwellers, artists and tourists. These coastal dwellings are also the sites of a number of small reservations where coastal Indians had fishing camps and lived from Salmon and berries or other fruits growing plentifully along the many streams.

Historically there were about 50 such tribes, each village being an independent unit. Today these tribes are organized in a loose confederation of Small Tribes of Western Washington, STOWW. The count of members ranges upward from 11 tribes recognized by BIA as entitled to federal services. It can include as many as 17 if it includes existing groups who sometimes assert claims to those rights. From time to time the number depends on whether or not individual tribes have joined or withdrawn from the confederation for present political advantages. Many of the news stories about fishing rights confrontations involve one or more of the STOWW tribes. IHS served these tribes through an office in Seattle known as the Western Washington Service Unit.

Organized separately only since 1974 is the Northwestern Washington Tribal Service Unit, primarily based at the Reservation. This serves the Lummi tribe, and the Nooksak and Swinomish. The last two are smaller reservations which like the Lummi are in the vicinity of Bellingham, Washington. The Lummi tribe is described by Vine de Loria as having

been " reduced to owning nothing valuable but the tidewaters around their reservation, and a short portion of beach access to the Bay". They have developed commercial techniques of raising oysters and fish through a sophisticated system of aquaculture which has gained national attention in the last three years. These Coastal Salish tribes are in close contact and exchange with similar Canadian tribes along the bays and rivers of British Columbia. War canoe competitions, ceremonial gatherings, tribal initiations and other contacts are frequent. The Lummi culture is related to that of the Northwest Coastal Indians of Canada and Alaska as well as the inland Salish tribes of British Columbia, Western Washington, Idaho and Montana.

Along the Northern Washington Ocean Coast the Service Units at Neah Bay serve the Makah, Quillette and Lower Elash Reservations. The Tahola Service Unit on the Quinalt Reservation also serves smaller tribes such as those at Hoh and Showalter. These tribes are also part of the Northwest Coastal culture often identified by its use of totem poles and wooden houses and large canoes. They once had highly developed social stratifications that included slave-holding and well developed ocean-related commerce centering around whaleing. These tribes, together with those of the Lummi Service Unit, represent the southernmost extension of this culture complex, which is also found in Alaska Area along the "panhandle". The availability of water transportation routes between islands and coastal or river communities unites these Northern and Southern extremes with the related Canadian clusters that lay between US points of contact.

The Puget Lowlands extend South as a narrow valley with some rolling hills, and connects with the Willamette valley in Oregon. Portland, located near the junction of the Willamette and Columbia Rivers is the main city south of the Seattle and its cluster of neighboring ports. Although

there are urban Indian populations in both the Seattle and Portland metropolitan areas, there are no reservations, and formal delivery of health or other services have only recently been considered federal responsibility. Some services are presently in the process of negotiation however, and the area Mental Health staff is consulting in the development of proposes and contracts. Chemawa Indian School, a BIA Boarding School for grades 9-12 is located near Salem, Oregon in the Willamatte Valley, not quite 100 miles south of Portland.

Just east of Portland, and running North and South from Canada to California is the Cascade Mountain Range. These are dramatic volcanic peaks, rising snow capped to 12and 14,000 feet. Among the famous peaks are Mount Baker and Mount Rainer visible from Seattle; Mount Adams (which in 1972 was in large part returned to the Yakima Indians who deem it of sacred importance); Mount Hood near Portland and Crater Lake in Southern Oregon, formed by waters that filled a crater of one of the extinct volcanoes. In Northern California Mount Shasta and Mount Lassen are also well known.

There are two large reservations that are mainly in the Cascades, and both lie along the Eastern slopes of the mountains. These are the Yakima Reservation in Southern Washington, and the Warm Springs Reservation in North Central Oregon. The Yakima Reservation is the home not only of the Yakima tribe who have always been based in this vicinity, but of 13 other tribes or subdivisions of tribes who were forced to cede their lands further west. The Warm Springs Reservation is similarly the home of not only the original Warm Springs tribe, but also the Wasco and some of the Northern Paiute bands. These tribes, unlike the coastal groups, had come in contact with the horse, and were participants in a hunting culture much like that of the central plains of the middle western United States.

As a part of the geologic history, the Cascades, during their period of activity as volcanoes, spewed out a tremendous flow of lava which covers the major part of Eastern Oregon, Washington, and Southwestern Idaho. This fairly high country is known as the Columbia Plateau, and is characterized by sage brush and grass that makes excellent grazing country and now is also utilized for wheat on a fairly large scale in some portions. It is characteristically horse country: One range of hills is named on maps as "Horse Heaven." The same characteristices that make it ideal for horses and cattle now, in the past supported buffalo, antelope and other herd animals. There are numbrous mineral and hot springs, and the soft lava is cut by deep gorges, the most famous of which is probably Hell's canyon, where the Snake river has cut down 8,000 feet along the border between Oregon and Idaho. There are a few older mountains that were not completely submerged by the lava flows. Among these are the Blue Mountains in the western reaches of Oregon near the Umatilla Reservation.

The Umatilla Reservation contains the Umatilla and Walla Walla tribes, as well as the Cayuse, whose skill with horses gave their name to tough Indian ponies used by cowboys throughout the West.

Located on the Columbia Plateau are not only the Umatilla Reservation but the Spokane; Colville, and Nez Perce, all of which also include portions of the Rocky Mountains that form the Plateaus Northern and Western boundaries.

In North Central Idaho is the Nez Perce Reservation, final home for most but not all of these large tribes which ranged over the Columbia Plateau and into the Rocky Mountains. The crest of the Bitteroot Range, which marks the Eastern Boundary of Idaho until it enters Yellowstone Park, forms a dramatic barrier to East-West travel. The Nez Perce, who claimed much of the Walla Walla Valley as well as the Mountains, were forced to cede so much of their land under the pressure of westward migration and agricultural development, that they finally decided in 1873 to leave the U.S. for Canada. The dramatic flight and pursuit led by Chief Joseph the younger, has been

frequently cited as a feat of logistics and military tactics, and a map of it leads across Wyoming and Montana, to within 30 miles of the Canadian Border, where the survivors were finally stopped and Joseph vowed to fight no more. The present Nez Perce Reservation is in the mountain valleys just East and North of Lewiston, Idaho.

One of the misunderstandings that led to this famous attempt to leave the US was the insistence on the part of federal officials that if one tribal leader signed, all of the tribe were bound by the decision. Among the Nez Perce as among many plains tribes, the leaders represented bands who followed voluntarily, and a "tribe" was a confederation of such leaders loosely bound by common objectives as well as common language and traditions. Two of these Nez Perce bands, one under Chief Moses, and another of those loyal to Chief Joseph the elder, who died nearby in 1872, are located on the Colville Reservation, bounded by the Columbia River as it comes south from Canada, and turns almost a right angle at the site of Grand Coulee Dam. Their large reservation is shared by a confederation of 11 tribes and portions of tribes. The Southern edges of the Colville Reservation are part of the Columbia Plateau, but the bulk of its holdings are in the westerly extension of the Rockies that eventually join the Cascades along the Canadian Border. There is one possibly true tale which says that the original land was reduced by a twelve mile strip along the Canadian Border, to prevent further attempts by the Nez Perce to cross into Canada.

The Spokane Reservation, stretching from the Eastern bank of the Columbia in a narrow strip lies almost wholly on the Plateau. It has health

services provided as part of the charge of the Colville Service Unit, but is developing its autonomy in these spheres as it has in its governmental and other functions.

The Rockies provide reservation sites for two other groups in Idaho. The Coeur d'Alene have a reservation along the south shores of Lake Coeur d'Alene, and the Kootenai have trust lands in the northern panhandle of Idaho, near the Canadian Border. The Kootenai, Coer d'Alene and Nez Perce are served from the Northern Idaho Service Unit with headquarters at Lapwai on the Nez Perce Reservation. Distances of 150 or more miles of rugged mountains between reservations does not encourage a great deal of interaction.

The Great Basin of the West, sometimes known as the Basin and Range region, is a semi arid desert that reaches from the great Salt Lake in the Northeast to Death Valley and the Salton Sea in the Southwest, and includes most of Nevada. Its northern boundaries follow the edge of the lava flows of the Columbia Plateau into Southern Oregon and again for a small part of Idaho just west of Fort Hall Reservation.

The Easternmost tribes in this IHS are the Shosohne and Bannocks who live on the Fort Hall Reservation along the upper stretch of the Snake River in Southern Idaho. Fort Hall was a major stop on the Oregon trail which entered the territory from Laramie and Caspar, Wyoming at Soda Springs (US 15) in the extreme South East corner of Idaho. Then it roughly followed the valley of the Snake River until about the point where it deepens into canyons that form the Oregon-Idaho border. There the trail crossed into Oregon and went northwesterly to Walla Walla, and thence along the Columbia River to the Coast or into the Portland and Willamette Valley sections. (US 80 follws much this same route today from Boise to Portland).

It may be of interest to note that the Western edges of the Basin and Range were the setting for another large scale and dramatic action against the US cavalry in the 1870's. This was the Modoc tribe's rebellion against

being forced to share a reservation with their traditional competitors and enemies, the Klamath. The Modocs were technically removed to Oklahoma, although some are still found in Northern California and Southern Oregon. The Klamaths terminated their claims for federal services in 1961.

C. Population of Area Indians Served by IHS

The total population of Indians listed in the 1970 census for the three states in the Portland Area is approximately 40,000. However, because of the terminated tribes, and the presence of large urban Indian populations in Seattle, Spokane, and Portland, the number actually served by IHS is markedly less than federal Census totals. A late 1970 estimate of the populations on those reservations where IHS has established Health Centers is given below:

1970 CENSUS REPORTS OF TRIBAL POPULATIONS
SERVED BY IHS SERVICE UNITS WITH ONE OR MORE MENTAL HEALTH STAFF

Region	Service Unit	Population estimates (1969-70)
WESTERN WASHINGTON:		
	Neah Bay	515
	Lummi	669
	Quinault	937
EASTERN WASHINGTON:		
	Colville-Spokane	3,726
	Yakima	4,800
IDAHO:		
	Lapwai	1,426
	Fort Hall	3,038
OREGON:		
	Umatilla	973
	Warm Springs	1,666
TOTAL:		17,750

This total is small compared with the total Indian population given in the 1970 census: Washington--33,386; Oregon--13,510; Idaho--6,687; Total--53,586. However the table does not include a number of other groups such as the youth at the Chemawa Indian School, and reservations for which populationsfigures were not available such as Coeur d'Alene and Kootenai in Northern Idaho. Since 1970, additional Mental Health staff would add 3,000 Indians of the STOWW group in the Puget Sound Area; at least 500 Nooksak and Swinomish near the Lummi Service Unit on inner shores of the Northern Puget Sound above Bellingham; and at least an additional 400 at Quillet and Lower Elash. When all of these groups are added to the earlier census population estimates, the figure for a grand total of Indians to be served by IHS is probably slightly more than 25,000. More complete census data is being compiled, but summaries were not made available for this report. Meanwhile this estimate of approximately half the total Indian population of the three states having IHS Mental Health programs in 1973 is probably a reasonable working figure.

D. Area Office and Transportation Links

The Area Office administering IHS programs for this three state Area is located in Portland, Oregon. At the time that the BIA established its headquarters there, this was probably the center of the population of Indians in the Oregon Territory, and chosen for its accessibility to the services of a major metropolitan center and by sea to the rest of the West Coast. However, with the termination of the Klamath and Grand Ronde-Seletz tribes of Oregon, it is now near the southern edges of the region to be served, as well as at the far western corner of the Area. There are historic links with the hospitals in Portland, however, since they provided care under government contract for the Indian and native populations from as far distant as Alaska until local resources developed. (See references to Morningside Hospital in the Alaska Area Chapter section on inpatient programs.) As Seattle

and the Puget Sound region developed some of this care has been shared with health facilities in that Area. In 1955 when health care for Indians was assumed by USPHS, one of the largest BIA hospitals was Cushman Hospital on the Puyallup Reservation near Tacoma. However this hospital was deactivated before Mental Health programs were initiated.

The Portland Area of IHS has no hospitals on any of the reservations, but provides outpatient and ambulatory care through a series of Health Centers on major reservations and satellite Health Stations on smaller reservations or at more remote locations on larger ones. When hospitalization for surgery or other specialty services is needed, these are provided through Contract arrangements with private hospitals or other appropriate health care providers. Sometimes these contracts are with local resources, but they also utilize facilities in the major cities of Portland, Seattle, and more recently Spokane.

Although many alternatives have been used, the automobile seems to be the only really satisfactory mode of transportation for staff from the Area Office who need to make regular visits to the various reservations. Indeed few alternatives exist for either staff or their Indian clientele. For instance, deep water transport has been available inland as far as Lewiston, Idaho since the early days of small steamboats, but is presently limited to freight because of its slowness.

Railway Passenger service, once vital to the region, has experienced a similar decline. The Union Pacific Railroad crosses East and West following the old Oregon Trail Route, and the Great Northern and the Chicago, Milwaukee St. Paul and Pacific Railroads find their way through more Northern Passes in the Rockies to Spokane on the Washington-Idaho border. The Great Northern and Northern Pacific cross Washington from Spokane to Seattle, one tunneling through the Cascades and the other sharing the Union Pacific route along the Columbia before proceeding North through the Puget Lowlands. The Southern

Pacific follows the Willamette valley south through the lower Cascades to San Francisco. None of these routes provide convenient passenger service to the reservations, and in some cases passenger service has been completely abandoned.

Busses do connect major cities, but these often leave the passenger from 15 to 75 miles from the IHS Service Unit, and the slowness and discomfort of busses are outweighed by the time savings of using commercial airlines to reach the same points. Airports are equally inconvenient, however, since an automobile must be available to reach reservations from major airports, whether these are at Seattle and Spokane or smaller cities such as Lewiston, Boise, or Pendleton.

The Cascades and Olympics in the West and the Rockies of the North and East as well as heavy coastal fogs are powerful deterrents to the use of small private aircraft. Although some use is made of planes by residents of the Columbia Plateau, they have never been seen as a practical way to meed the needs of the Portland Area Mental Health Staff.

Fortunately highway development has been good, and major highways connect Portland with the population centers near most reservations. Although the maintenance of local roads on reservations is a federal responsibility, except in those instances where major State arteries are involved, maintenance is a chore that often falls between the cracks in tribal disputes over sovereignty and responsibility. However, to many observers it seems that throughout the Portland Area roads are better in quality and maintenance than on many reservations in other parts of the US. Area Office Personnel prefer to drive the total distances between the reservations in Oregon and Washington, using commercial flights to reach the vicinity of the Idaho reservations, and arranging for government cars or colleagues to provide local transportation at those points. Round trip drives of 700 to 1,000 miles are a weekly occurrence.

II. EARLY MENTAL HEALTH ACTIVITIES (PRIOR TO 1969)

A. University of Washington Medical School

1. Yakima

In the Spring of 1966 Mr. Richard Gaulke, MSW, IHS Social Worker at Yakima, organized a Health Care Conference on the reservation. Representatives from all Western tribes were invited, as were Area and Washington PHS officials and Regional HEW staff. Among the consultants at that conference was Dr. Mansell Pattison M.D., a Social Psychiatrist from the University of Washington Medical School. Dr. Pattison presented to the conference a discussion of the concepts of preventive mental health, and of mental health consultation, emphasizing the use of local resources in the Indian community. The resulting discussions led to considerations of the possibility of establishing a mental health consultation program.

By the summer of 1966 administrative details had been worked out, and Dr. Pattison began a one day a month consultation program to the entire staff at the Yakima IHS outpatient facility. For the next four years, until he moved to the new medical school at WC Irvine, Dr. Pattison drove or flew to Yakima every month.

The subjects of consultation ranged over the gamut of community mental health activities: community organization, medical consultations and case management conferences, personal guidance for staff members, and administrative matters. Local staff and tribal leaders made effective use of this resource, utilizing it in a variety of appropriate ways. Something of the flavor of the relationship, especially the mutual respect involved is revealed in Dr. Pattison's "Exorcism and Psychotherapy: A Case of Collaboration" which is Chapter 21 in Religious Systems and Psychotherapy, edited by Richard H. Cox and published by CC Thomas, Springfield, Illinois, 1973.

In the first half of this chapter a case history is sensitively presented in which the referred adolescent patient and her mother first discuss some basic

traditional beliefs which could account for the symptoms, and are then encouraged to utilize traditional healing methods and the assistance of the elder members of the community who know the proper ritual procedures. The second half discusses the processes of the therapy from the points of view of anlaytic and other schools of psychotherapy.

Dr. Pattison points out that a non-Indian professional has a choice of models to frame his relationships with indigenous healers. He outlines briefly three relationships: That of total separation: that of competitive suspicion; that of consultation between experts, and his own preferred model of active collaboration and mutual support.

With his basic orientation he was able to demonstrate the clinical and organizational utility of a mental health consultation program to local and Area IHS staffs. Further he demonstrated that a professional could be supported by the local Indian community and that he could be implemented in a way that integrated with the Indian counselor, and CHR, and home health aide programs. These aspects of the consultation won the interest, support, and involvement of the Area Office staff and paved the way for later formal mental health programs.

This program is an example of a demonstration or pilot project which remained viable, and did not expire when its first contractual arrangements expired, or upon the departure of the original demonstrating professional person. That Mr. Gaulke has remained with the IHS Service Unit at Yakima through these years has undoubtedly contributed to the local continuity, and it is regrettable that he has not written up the program from his point of view. Perhaps in the future he will be able

to do so.

This, together with the second demonstration to be described in connection with the Makah Tribe and Neah Bay Service Unit provided the IHS with sufficient confidence in the potential usefulness of Mental Health Programs, and of the viability of the model to institutionalize and formalize the models into a constantly expanding series of programs far beyond the initial input of the first consultant. In anticipation of future material it might be appropriate to note that one of Dr. Pattison's students, Dr. James Shore, became in due time the first Chief of Mental Health Programs of the Portland Area IHS. This mirroring of the developments in the Billings Area, where a resident under Dr. James Barter became the first Chief of Mental Health Programs, suggests that this may be a model worth scrutinizing for further application to the solution of problems of manpower and recruitment.

2. Neah Bay

Following the first year's success at Yakima, the IHS Area Office asked Dr. Pattison to extend his consultation activities to other Service Units, and the Makah tribe at Neah Bay was added to his consultation schedule. By 1968-69 Dr. Pattison and the Area Office had developed a plan for some of the senior residents in psychiatry to have field experience working with Indian populations. Two residents were selected, and developed detailed plans of their own work at Neah Bay.

The Makah tribe of about 500 people, lives at the extreme northwestern tip of the Olympic peninsula, where Neah Bay forms a snug harbor. There is

an IHS field station, with a full time resident physician and a Public Health nurse to provide a major resource and contact with the tribal community. The Makah had also just recently entered into the new program where IHS monies hired Community Health Representatives to work under tribal contract to provide a link between the IHS and other health resources and the residents of the reservation. As a group they were interested in consultation which would help in orienting and training these new employees. It is interesting to note that three of these original Portland area CHR's have become Mental Health workers.

The Makah were also the subject of concern for a number of other reasons. Until the opening of a paved road in the year 1931 they had been more isolated than most of the tribes in the Portland Area, since access to their reservation was limited almost entirely to waterways, through the Straits of San Juan de Fuca or along the Pacific Coast. The opening of more paved roads from Port Angeles to Neah Bay was going to accelerate the cultural contact and the cross cultural stress of the population. This same feature also made it accessible from Seattle, so that staff and residents could maintain contact while also continuing their studies and professional activities within the city.

The projects undertaken were supported in part by funds from the State of Washington appropriated for research in medicine and biology, and partly by the use of facilities of the IHS. J. David Kinzie, M.D. and James B. Shore, M.D. with supervision from Dr. Pattison, spent two days a week on the Makah reservation and developed a model for consultation as well as epidemiologic studies of significance. One paper which they jointly prepared, the "Anatomy of Psychiatric Consultation to Rural Indians" was presented at a meeting of the American Psychiatric Association, and subsequently published in the Community Mental Health Journal, July 1972.

This article is reproduced because the model for psychiatric (Mental Health) consultation developed during this project became the model extrapolated to the entire Portland Area. While there have been modifications based on experience,on variations in local tribal and Service Unit conditions, and as accommodations to new personalities and circumstances, this description of the Makah consultation remains the prototype of later development of Mental Health Programs in the Portland Area.

------ANATOMY OF PSYCHIATRIC CONSULTATION TO RURAL INDIANS----------

J. David Kinzie, M.D., James H. Shore, M.D.
E. Mansell Pattison, M.D.

This paper describes the establishment of a community mental health consultation program in a rural, isolated, Indian community with minimal mental health resources. Our aim is threefold: 1) to describe appropriate administrative procedures for establishing consultation in a complex political milieu, since this is the first formal ongoing psychiatric consultation program carried on directly with a tribe of Pacific Northwest Coastal Indians; 2) to describe the development of a community consultation program directed toward an entire community and not just to specific agencies; 3) to describe methods employed to analyze the process and progress of a consultation program that may be used for self-evaluation.

The initial request for the development of consultation programs to Indian communities came to the Director of the Social and Community Psychiatry Program, University of Washington, from the area office of the Indian Health Service. The selection of the particular community was based on its social and geographic setting which made it a feasible locus to establish both a consultation program and conduct epidemiologic studies of mental health in the community to be served.[18] The project was staffed by two senior psychiatry residents (JDK, JHS) under the aegis of the program in Social and Community Psychiatry (EMP). The staff spent two days weekly at the Indian community over a period of six months for a total of 44 community consultation work-days. Longitudinal data was systematically recorded during the course of the project for analysis.

The Community

The community chosen for this project is a rural village with a population of approximately 500 persons, including about 250 children. There are only a handful of non-Indians, save for those who are married to Indians of the tribe. The village is the main settlement on a large Indian reservation, located on the Pacific Northwest seacoast, with fishing and lumbering the main industries. Historically these Indians were primarily a seafaring people who spent their lives on water or close to the shore, seldom venturing more than a few miles inland. Whale hunting, for which they had elaborate techniques and rituals, played a central role in their traditional culture. They were an aggressive, warlike people, who made frequent raids against neighboring tribes from which they returned with captives. Warfare was of secondary importance, however, to a people engrossed in whaling and in the potlatch, their ceremonial feast of giving. This ceremony afforded an alternative to warfare, a means of humbling rivals, and the opportunity to enhance the prestige of community leaders. Prior to their treaty with the U.S. Government in the nineteenth century the culture had remained relatively isolated. The arrival of the Indian agent following formal treaties dramatically changed this picture. There was major socio-cultural disorganization accompanying the prohibition of tribal customs, the suppression of the potlatch and other ceremonies, an enforced shift from whaling to local fishing and agrarian pursuits, and the forced education of the children in English-speaking boarding schools. Nevertheless, the village remained relatively isolated as an ethnic group until a road was built in 1930 which

connected the village to the outside white civilization. This brought the impact of another culture rather forcefully on the village, even though their geographic distance has continued to provide a degree of isolation. Subsequent to the Indian Reorganization Act, which gave them the right of self-government an effective Tribal Council has been formed that has become a powerful community force. Recently their resources in lumber, fishing, and recreational lands have provided opportunities for economic growth. The village presents an admixture of geographic, social, and cultural isolation that has allowed the Indian tradition to remain somewhat viable, while at the same time there is contiguity to white American culture that provides ample pressure toward cultural change. Thus the Indian residents of this village represent a people who are a minority group, a rural group, a poverty group, and a small society undergoing rapid social change and cultural disorganization.

The village is located 50 miles from the nearest population area, and mental health professionals are almost 150 miles away. Since 1967 the community has been served by a full-time physician assigned through the Indian Health Service. He works in a small medical clinic, assisted by a full-time Indian Public Health Nurse. Since 1968 the community has also had two full-time Indian Community Health Representatives (C.H.R.), who are residents of the community. These two women function in a paramedical capacity. They are employed by the Tribal Council, and their job responsibilities focus on the identification of health needs of the community in order to organize appropriate community actions, as well as to help individual persons.

A Model for Mental Health Services in a Rural Community:

In anticipation of the development of a mental health consultation program, we sought to develop a model for the services we might reasonably provide. Plans for urban community mental health center programs have emphasized the need for comprehensive services, including inpatient, outpatient, day-care, emergency services, and consultation and education service. (5) However, in rural areas far removed from mental health resources such a model of community mental health services is inappropriate. A series of recent case reports on rural community mental health programs have stressed the development of indirect services, rather than a panoply of direct care programs. (3,7,8,15) These rural programs have emphasized mental health consultation to primary-care agents in the community, community education programs, and the coordination of existent services in the community.

The problem of providing some type of direct mental health service still remains for rural community mental health programs. Some workers suggest that the development of a rural indirect program of consultation must be supported by some direct clinical services by the consultation

team. (4,11) On the other hand, others (17,21) have stressed the need to train and supervise indigenous non-professionals from the community who will then provide major direct care services. Mahoney and Hodges (12) suggest that the particular model of services for rural areas is less important than the commitment, flexibility and creativity of mental health professionals in response to the needs of each particular rural locale.

In terms of Indian communities there is not only the problem of the rural community, but also an ethnic minority that exists in a complex socio-political milieu. Recent reports on Indian mental health services have stressed the need to develop programs responsive to the socio-cultural setting of Indian life and the role of Government-Indian interaction as points of intervention for indirect mental health services. (9,14) In addition, Stage and Keast (19) have described the development of successful direct clinical services with the Plains Indians, indicating that psychodynamically oriented psychotherapy could be appropriately conducted with members of this subculture.

With the above concepts in mind, we proposed a consultation program that would first, address the socio-political structure of the Indian village; second, move to develop consultation relationships with major institutions and personnel of the village; and third, offer a modicum of direct clinical service where appropriate.

Developmental Course of Consultation:

The Socio-Political Course of Consultation:

The first step in the consultation program was to investigate the socio-cultural dimensions of the community, including the political structure. The consultation team reviewed available anthropological research on the history, structure, and function of the Indian tribe of which the village is a part. Consultations were sought from several anthropologists, psychologists, social workers, and physicians who had been recently involved with the tribe and similar Indian groups in the area to apprise ourselves of current attitudes, problems, and community function. This background information proved highly advantageous in anticipating community needs and responses.

In the course of this preliminary investigation we were informed of a variety of experiences in establishing community programs in Indian communities that had not proved successful. In most instances such programs had not successfully worked out political sanctions such that in one manner or another they failed to gain community support. The importance of establishing community knowledge, sanction, and support of community mental health programs has been repeatedly emphasized in the literature as a critical variable for the establishment and maintenance of community programs. (1,2,13,20) Therefore we set out to gain such sanction.

This involved three distinct political entities: the Indian Health Service of the U.S. Public Health Service, the Bureau of Indian Affairs, and the local Tribal Council. The supervisor of the consultation project (EMP) had developed a working liaison with the regional offices of both the Indian Health Service and the Bureau of Indian Affairs. Therefore both offices were aware of the interests of the Department of Psychiatry in Indian mental health problems. Further, the participation of the supervisor in programs of both government agencies had provided the opportunity for personal contact and the development of a degree of personal rapport. Based on these established relationships, the consultation team developed a written proposal for consultation that was formally presented to each government agency, with mutual knowledge that both agencies were to be involved in sanction of the project. The written proposal was followed by personal interviews by the consultation team with officials from both agencies. This afforded an opportunity to clarify questions regarding procedure, responsibilities, and attitudes. In view of the questions raised, we feel that this part of the consultation project was essential in order to obtain both official and moral support of these two government agencies. Both agencies have a degree of responsibility for the conduct of affairs on the reservation, and without their full-fledged support we could not have been able to approach the community.

After official sanction had been granted by the two government agencies we next approached the local Tribal Council. As with many community enterprises, the development of a community mental health consultation project carried with it political overtones. Hence the local Tribal Council received our formal consultation proposal and granted informal approval, but did not act immediately in terms of official action. We were informed that we could now proceed to establish working relationships with the community. We did so with reluctance, in view of the informal nature of our local sanction. However we did commence consultation with the understanding that official council action would be forthcoming. However it was only after we had worked in the village for several months that the Tribal Council took official public action to sanction our work. As the consultation work proceeded we were introduced to a number of politically sensitive problems in the community that directly involved the tribal government. At that point, the fact that we had official local sanction enabled us to work openly with the community problems and contribute to successful community responses.

In all, this preliminary work of orientation of the consultation team and the negotiation of the three political contracts took six months of work before the team actually began work in the village. We feel, however, that this investment of time is a critical prelude to successful consultation in such a socio-political milieu.

The Course of Indirect Consultation Services:

Upon completion of negotiations with the community to develop a consultation service a decision had to be made regarding our point of entry into the community. Because of the size of the village (500 population) there were few formal organizations that served the community, most major human services being provided via the two government organizations. The main health service was the small medical clinic, staffed by a Public Health Service physician and a local Indian nurse. The nurse had worked in the community for many years and was identified as a major figure in the community to whom those in need could turn. In addition, the local Tribal Council had just hired two women of the community to serve as Community Health Representatives (C.H.R.'s). These two women were initially assigned to the health clinic as a working base for assessing community health needs. Therefore, the health clinic and its associated personnel were chosen as the initial entry point into the community.

At the time of our entry into the community there was a strong positive image of the medical clinic, both in terms of its medical services provided and the personalities of its staff. On the other hand, the community had little acquaintance with mental health concepts or professionals, the main acquaintance being with social work and counseling personnel who did not have a very positive image in the community. Therefore, the consultation team chose to identify themselves rather strongly with the established medical tradition which had informal community sanction, and the team presented themselves to the community in the role of physicians and healers.

The first consultation contact was made with the local physician and the nurse. After a period of mutual exploration the physician and nurse indicated their interest and need for mental health consultation. Regular consultation time was established with the physician to discuss mental health aspects of the general medical practice of the community. Then problematic cases were brought to the consultation sessions, and gradually a style of consultation was established in which the consultants dealt with general problems of practice, specific case evaluations and brief therapy, and reviewed ongoing problem cases that the physician continued to manage in his practice.

At the same time consultation relations were negotiated with the two C.H.R.'s. These two women had no formal health service training, save for the brief orientation provided in the C.H.R. program. Each consultant met individually with a C.H.R. in addition to joint consultation conferences with the entire clinic staff. The initial period of consultation was much

protracted here, for these persons had very ambiguous roles to perform in the community. Thus much of the early consultation work centered around an exploration of mutual roles between the consultants and the C.H.R.'s. The C.H.R.'s spent much time presenting their activities in the community, with an attempt to clarify community issues and define the role which the C.H.R.'s could play.

Over time the C.H.R.'s became more confident and competent in their community roles. As a consequence they became active in case identification and case referral to the medical clinic. In some instances the C.H.R.'s assumed a direct therapeutic role. Such cases were brought to consultation for review and supervision. Through these experiences the C.H.R.'s gained psychiatric knowledge and developed a capacity to function in a therapeutic role with decreased anxiety. As the consultation work progressed with the C.H.R.'s they were able to detach themselves from the medical clinic and began to function more autonomously as representatives of the community. This was reflected in the relocation of their offices in the tribal headquarters, and finally a shift in functional authority from the physician to the appropriate tribal officer in charge of health affairs. A degree of success in consultation with these C.H.R.'s was reflected in a request for the consultation team to conduct an area-wide mental health workshop for C.H.R.'s from all the regional reservations. Upon completion of that workshop the participants recommended that further workshops be developed by the consultation team at regular intervals.

As a firm base for consultation was developed with the clinic staff and the C.H.R.'s, the consultation team began to look at other parts of the community. Through contacts arising out of case problems the consultation team arranged conferences with the local school administration, the part-time school counselor, part-time welfare worker, Head Start teachers and parents, the local Indian police, and the local Indian Community Action Program. An evaluation of these community contacts revealed that there was a definite gradient of ongoing contacts. Those organizations that were relatively close to the bureaucratic structure engaged in negotiation of an informal consultation arrangement (the school administration, school counselor, welfare worker). Those who were more distant from the government bureau and more identified with the local Indian culture were not receptive to an ongoing relationship (police, Community Action Program, Head Start). While no contact at all was made with the local ministers and traditional Indian organizations. Thus it appears that our point of entry facilitated open access to the more formally structured parts of the community, but at the same time precluded easy access to the more informal structure of the community.

In sum, over a six month period an effective working consultation program was established with both the medical clinic program and the C.H.R. program. Both groups made effective and appropriate use of the consultation with the result that mental health problems became clearly identified and directly cared for by both groups of local personnel. Case-oriented consultation conferences on a periodic basis were established with some other parts of the community, but the more indigenous and informal part of the community were not broached in the consultation program.

The Course of Direct Consultation Services:

Although the consultation program did not plan to offer major direct services, we did plan to offer diagnostic services and crisis-intervention brief therapy where appropriate. After the initial period of consultation contract negotiation the team began to receive referrals for brief therapy. Since it was mutually understood that long term therapy would not be provided, the therapy contacts were structured in terms of evaluation of the immediate crisis, crisis resolution, and planning for ongoing contact that would be continued by either the medical clinic staff or the C.H.R.'s. We found that the referrals were appropriate to the above structure. Persons were referred who either were exhibiting socially disruptive behavior or were experiencing severe symptomatic distress. The patients were found to exhibit a reasonable degree of psychological-mindedness such that a psychodynamically oriented brief therapy could be feasibly conducted. We found that it was clinically feasible to conduct a crisis-intervention type therapy program, for although there was no definitive resolution of psychiatric problems, the immediate crisis could be adequately dealt with, and then the patient could be followed subsequently by the community personnel available. In this manner we found that some rather severe problems could be handled within the community rather than referring such problematic cases to distant resources.

One third of the consultation contacts were devoted to direct clinical services involving both diagnostic evaluation and brief therapy. There were 52 patient contacts with 21 patients. Thus the patients were seen on an average of 2-3 times.

Figure 1 summarizes the population who received direct psychiatric services.

As expected, over half of the patients were referred by our main community contacts. However, we were surprised to find those who came seeking treatment upon learning of our presence in the community. This finding in combination with our clinical experience supports the contention that psychodynamic psychotherapy is a feasible treatment technique for comparable Indian populations.

The majority of the patients were young adult women, while only one adult male was seen. This is in keeping with the general medical experience: the younger Indian women overutilize the clinic, while the younger Indian men underutilize the clinic.

The adolescents and children were all males, and with one exception, were referred because of delinquency, school underachievement, or disruptive classroom behavior. This is in contrast to the adult women whose symptoms involved subjective distress, such as depression and anxiety.

Special mention must be made of the suicidal attempts because of its high incidence. During the six month period there were 11 suicide attempts, none successful, involving 7 persons. These included 3 adult females, 3 adult males, and 1 adolescent male. The females and the adolescent male were diagnosed as reactive depression. They were seen in psychiatric consultation and were subsequently continued in care in the community. The adult males were all diagnosed as alcoholic. Although all were seen immediately by the physician, all these men either rejected or failed to follow through on the psychiatric referral that was made.

In a parallel epidemiological study that was conducted in the community, we found that 27% of the community had demonstrable impairment from alcoholism, and 15% had impairment from psychophysiologic reaction, primarily peptic ulcer (18). These two classes of illness were the most common aspects of mental illness in the community. Yet these persons were not referred for psychiatric evaluation, although such cases were brought up for consultation discussion. Our epidemiologic data indicate that alcoholism is not defined as an illness in this community and medical aid is not seen as an appropriate response to alcoholism. Whereas psychophysiologic illness is seen as solely a medical problem, for which medication is taken, but with the avoidance of the emotional implications of such diseases. In consultation discussion with the medical personnel and the C.H.R. personnel we were able to provide assistance in the management of these two types of mental health problems. Since the community personnel did follow through in the management of these cases we feel that such indirect psychiatric service may be more appropriate in this cultural context than the attempt to redefine these problems as psychiatric illnesses. To do so would not change community attitudes, would not bring such patients under psychiatric care, and might well diminish the motivation of the community personnel to deal with such persons using their own local resources.

In sum, a modicum of direct service was offered that proved to be feasible in terms of the consultation time available, the therapeutic goals, and the opportunity to assist the community personnel in the management of relatively severe psychiatric problems.

Our experience supports the recommendations of others, that in isolated rural areas some initial direct clinical service may provide the necessary first stage of psychiatric management in the conduct of a mental health service that is primarily focused on indirect service.

Overview of Consultation:

During the six month period the consultation team provided a total of 44 work days in the community. A total of 152 contact consultation sessions were conducted. These were divided into the following categories:

Consultation with medical clinic personnel and C.H.R.'s	72
Consultation with community agencies	28
Direct patient service consultation	52

As can be seen, approximately one-third of the consultation work was devoted to direct patient services. However, these direct services channeled back into ongoing community care. About one-half of the consultation time was devoted to those who were directly involved in the community as primary care agents. And only about one-fifth of the time was devoted to consultation with non-health community agencies.

In this light, one would anticipate that the consultation services would not have a direct impact on mental health attitudes in the community. However, the work with the community personnel related to health care did have an impact on official attitudes of the various governmental and tribal representatives. Thus, concern for community health and mental health problems has been expressed, and continued support of mental health oriented programs has been forthcoming.

Our experience in this consultation project suggests that the demonstration of useful and practical methods of response to mental health problems may prove a viable entree to a community. Whereas more abstract community mental health programs may not garner community support, at least initially, if the community is unable to see any demonstration of how mental health services can be of value to them.

Another method of evaluating the function of consultative services is to record the focus of consultative sessions, following the method of Griffith and Libo. (6)

In Figure 2 we chart the content of consultation sessions for each month of the project. It is evident that the majority of the early consultative sessions were devoted to establishing relationships between the

consultants and consultees. As rapport developed case referral and case consultation began to assume the major focus of consultation. This demonstrates that patient-oriented consultation was successfully accomplished. However, it also demonstrates that extension into the community came to a relative halt after the first initial contacts. Further, it demonstrates that the function of increasing inter-agency collaboration gradually decreased to a negligible point.

This graphic analysis of consultative function reveals then that only some of the goals of indirect mental health consultation were accomplished in the six month period, namely the development of fairly effective case identification and case management. However, the goal of more effective community agency interaction is demonstrated to still be unmet, with little consultative activity directed toward that goal. Thus this analysis points up the need to focus further consultative attention to these areas of community interaction, including more active work on the part of the consultants to establish broader relations within the community.

Discussion:

Our analysis of this consultation project has been aimed at developing a method of evaluation of community consultation based on readily available clinical parameters. Recent emphasis on evaluation of community mental health programs have stressed the need to base such programs on sound mental health epidemiology. (22) However, nascent programs cannot depend on the completion of sophisticated studies before establishing community programs. On the other hand, less exquisite methods of immediate evaluation can provide data for feed-back to the community, as well as provide a degree of self-evaluation for the mental health professionals involved in program development. (1,10,16)

The methods of analysis used in this project have provided us with some admittedly rough, but reasonable guidelines for the continuing development of this consultation project. We have demonstrated that an active mental health consultation program can be developed with a rural, isolated, Indian community. Such a program can provide significant input into the total mental health effort of such a community. The development of such a program in a complex socio-political milieu, however, must be based on the negotiation of appropriate sanctions from governmental and local political units. Further, the development of mental health services must be developed within the political, social, geographical, and economic parameters of the community, rather than the application of a stock model of mental health services.

Our experience indicates that a mental health consultation program to a small community such as this, will inevitably become involved with all of the cross-currents of the community. Thus the consultation program must be prepared to deal with all aspects of the community, and not with a particular isolated agency.

By analysis of our consultation work we have been able to define certain segments of the community with whom satisfactory relationships have not been established, and we have been able to identify classes of patients that will and will not be directly accessible. The use of such clinical evaluative methods provides a measure of corrective self-evaluation.

Our experience in direct clinical services indicates that diagnostic and brief therapy services fulfill critical needs in the community and serve to augment the indirect services of the consultants. The training and supervision of Community Health Representatives as indigenous health workers provided both manpower for continuing care as well as a vital link to other segments of the community.

Finally, although the consultation project was formally contracted for a six-month period, the community did indicate its acceptance and recognition of value of the program by a request for an ongoing consultation program. Consequently a re-negotiation was carried out between the local Indian community, the Indian Health Service, and the Department of Psychiatry, resulting in a commitment by the Department of Psychiatry to provide ongoing consultation to the community, with financial support from the Indian Health Service.

Summary:

This paper describes the establishment of a community mental health consultation program to a rural, isolated Indian community with minimal health resources. The first step in the program required six months of negotiation to obtain appropriate sanction from the Indian Health Service, the Bureau of Indian Affairs, and the local Tribal Council. Entry into the community was made via the local medical clinic and the Community Health Representatives. Consultation with these personnel developed into a successful method of indirect case management, backed up by a modicum of direct diagnostic and brief therapy services. Analysis of community contacts and consultation content revealed that after initial community exploration the consultation services did not continue to grow further into the community. This analysis provided a useful clinical evaluative procedure which indicated directions in which the consultation services required further development. Community acceptance of the consultation program has resulted in a continuing contract with the community to provide such mental health consultation.

Figure 1

Population Characteristics in Direct Patient Services

N=21

Source of Referral:

Physician	7
C.H.R.	5
Self	6
Other	3

Age and Sex Distribution:

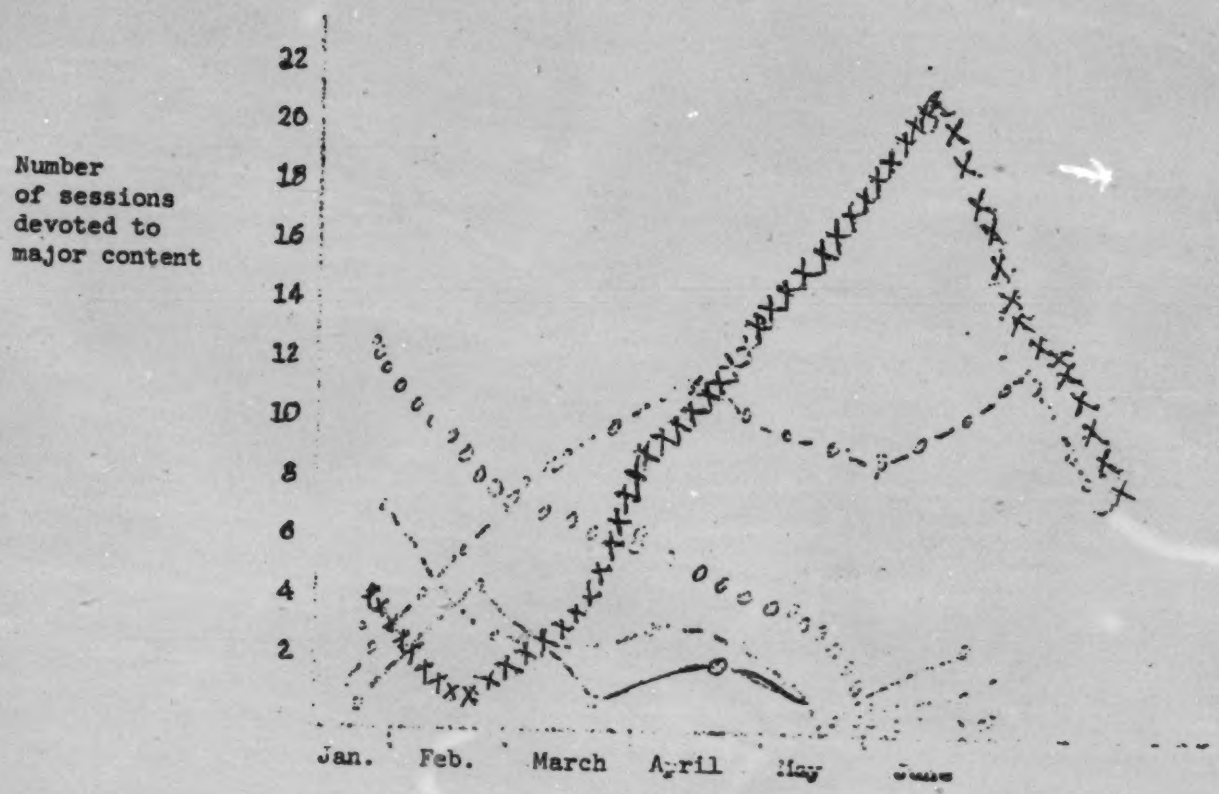
Adult Females (age range 22-55, mean 32)	13
Adult Males (two additional males seen in families)	1
Adolescent Males	4
Adolescent Females	0
Child Males	3
Child Females	0

Major Problem for Referral:

Depression and/or Suicidal	7
Anxiety	4
Family Conflict	3
School Adjustment Problems	3
Dysocial Behavior in Adolescence	3
Alocholism	1
	1

Figure 2

Content Analysis of Consultation Sessions



Categories of major content of consultation

ooooo Getting acquainted-establishing rapport

----- Becoming visible as a resource

_____ Expediting inter-agency collaboration

-o-o-o Case-consultation

xxxxx Direct patient service

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B. Fort Hall Suicide Prevention Program

At the same time that the consultation work was being developed at Neah Bay in the far northwestern corner of the Portland Area, another line of interest in Mental Health problems was being developed in the southeastern corner of the Area, at Fort Hall. In the Fall of 1966 the Tribal Council of the Shoshone Bannock Tribe and the BIA Superintendent, mobilized by an epidemic of three suicides within a very short period of time, approached the IHS staff and Area Office for a coordinated study and attempt to solve this problem. Mr. John Bopp, MSW, was SUD at Ft. Hall, and with support from Dr. Stanley Stitt, the IHAD, he got in touch with the Los Angeles Suicide Prevention Center and with the National Institute for Mental Health to request support for a study and experimental approach toward alleviating this problem. By the Spring of 1967 consultants from the newly formed NIMH Center for the study of Suicide Prevention had sent consultants who conducted a seminar in the Fort Hall. They stressed the concept of "community gatekeepers," and tried to teach a broad definition of this concept of persons to whom members of the community might go, as well as be sent, in times of crisis. They also delineated the need for an alternative to jail for the acute detention of self destructive individuals.

This eventful meeting was attended mainly by non-Indians in the community, but it did include some "gatekeepers" such as the Supt. of BIA agency who arranged for some further talks with tribal leaders. A visit of the Senate Indian Education Committee was followed by a suicide of a 16 year old high school student who had been peremptorally jailed under a charge of drinking during school hours. The case notes, analyzed later by one of the NIMH Consultants, Dr. Lawrence Dizmang, M.D., showed that within the preceding school year two other Indians had used the same rope

and materials in the same cell of the jail, and that one of these had been a 17 year old girl from the same school.

During the summer of 1967 there was an epidemic of 30 suicide attempts within one month, and district meetings for suicide education began to truly involve the tribal groups as they were held throughout the reservation on a district basis over the next six months. The accompanying timetable, taken from an article published by the staff, will help clarify the chronology of these events, and those to follow.

By spring of 1968 the IHS aided in the development of a proposal to NIMH for developing a Community Treatment Center, particularly a holding facility that could be an alternative to the use of Jail cells for self destructive persons. The Tribe developed a service organization, based upon tribal volunteers with staff consultants as back-up for clinical services, and also enlisting the services of a local psychiatrist in private practice. A Research Assistant from the NIMH Suicide Prevention Center joined this staff as project officer, in order to gather data and study the elements of the problem, while providing a needed service.

The Fall of 1968 saw the tribe take possession of the IHS health service building under the provisions of the contract. This followed the model of developing a contract for service which a tribe could specifically assume, leaving or returning control of local problems appropriately to the local community. IHS and BIA Social Workers and IHS physicians continued to provide professional staff coverage, and to participate as the tribe desired.

When the holding facility opened to receive its first patients in 1969, it was indeed a multiple resource operation: Indian counselor attendants, mainly parent and grandparent generation volunteers who had had considerable training from the NIMH, and other interested professionals

FORT HALL SUICIDE PREVENTION CENTER

Chronological Development of the Center

September 1966:

An epidemic of three suicides highlighted the need for immediate action. This led to a formal resolution of concern by the Indian tribal council. Concern had been actively expressed by the agency superintendent of the Bureau of Indian Affairs and the clinical social workers.

November:

The Indian Health Service contacted the Los Angeles Suicide Prevention Center and NIMH to request consultation support.

February 1967:

Consultants from the newly established NIMH Center for Studies of Suicide Prevention conducted a seminar in the local community. Consultants stressed the concept of "community gatekeepers" and establishment of a "holding facility" for acute detention of self-destructive individuals as an alternative to jail. The seminar was attended by the non-Indian community. The superintendent of the Bureau of Indian Affairs arranged a meeting of the consultants with tribal representatives.

Spring:

The Senate Indian Education Subcommittee visit was shortly followed by another suicide. This called renewed attention to the seriousness of the problem.

Summer:

District meetings were held on the reservation for suicide education and to stress the concept of community participation through community gatekeepers. An epidemic of suicide attempts (30 in one month) occurred during this time, reenforcing the need for suicide prevention.

July:

There was an NIMH consultant follow-up visit.

March 1968:

Tribal community education meetings continued. Recruitment was started for community volunteers as Indian counselor-attendants. Initially there were 19 volunteers; most of them were women.

Spring:

The Indian Health Service assisted the tribe in developing a service maintenance organization, which was turned over to the tribal council. A model provided for the tribe's assuming control of a specific aspect of health service.

Summer:

A research assistant in suicidology joined the holding center staff. An NIMH consultant served as project officer. The investigation into the nature of adolescent suicide began (3).

November:

The Indian Health Service building became tribal property as the medical holding center and the headquarters for the suicide prevention service. The tribal health committee participated in the plans for the medical holding center and the recruitment of folunteer counselor-attendants.

Spring 1969:

The Indian Health Service and Bureau of Indian Affairs social workers provided professional staff coverage. Indian Health Service physicians participated.

May:

The tribal council published guidelines for the medical holding center. The center admitted its first patient.

Summer:

Multiple resources participated in the operation of the medical holding center: Indian volunteer counselor-attendants, Indian community health representatives, Indian Health Service and Bureau of Indian Affairs social workers, Indian Health Service physicians, a psychiatrist on contract, participants from Volunteers in Service to America, the tribal health committee, a summer medical student fellow, and consultants from the newly created Indian Health Service Mental Health Office.

were day to day mainstays of the program. Indian CHR's were not only case finders, but also active links between individuals referred and their families. IHS and BIA Social Workers provided their services in the same tasks and as backup consultants to CHR's. IHS physicians provided medical examinations and care; and a psychiatrist on contract was also available. Vista volunteers and members of the Tribal Health Committee were involved in the planning, overseeing, and manning of the center and its follow-up activities.

By the summer of 1969, with the formal organization of the Portland Area Mental Health programs, one of the three professional staff paid out of the Mental Health budget was a social worker assigned full time to Fort Hall with a major mandate to work with the tribe on this program. It has remained an integral part of Area Mental Health services since that time. The development and operation of this program is reported in the article by James Shore, John Bopp, Thelma Waller and Thomas Daws entitled "Suicide Prevention Center on an Indian Reservation," American Journal of Psychiatry, 128:9 March 1972, pp. 76-81.

A briefer description of the program, after its first calendar year of operation was nearly completed, is contained in the first report of the Area Mental Health Programs to the IHAD in December 1969.

THE MEDICAL HOLDING FACILITY

> The medical holding facility at Fort Hall, Idaho was developed in a coordinated effort by a number of care agencies including the Shoshone-Bannock tribal council and health committee, officials of the Bureau of Indian Affairs, the Indian Health Service, and consultants from the National Institute of Mental Health. A group of tribal people and VISTA members have volunteered their service as indigenous counselor-attendants to staff the treatment center. This holding facility was designated to treat Indian adolescents and adults whose behavior and past history indicate that they are potentially self-destructive. This has served to take many people who were in jail or in temporary police custody and treat them as medical psychiatric patients rather than

criminals or prisoners. It was the intent in planning the holding facility to place special emphasis on the juvenile group because of their past record of numerous suicide attempts. Young people were formerly placed in jails that were not designed to care for them or to respond to their emotional crises.

The facility also has provided a method of follow-up care for patients after they are discharged. This involves the coordination of medical, psychiatric, and social service personnel and is an attempt to insure a continuity of helping services for identified patients.

The overall administrative management and direction of the facility comes from the Shoshone-Bannock tribal council and their designees. Coordinated grant applications for an expanded facility are now pending. The facility itself is a single house dwelling that was remodeled by the Indian Health Service to meet the requirements for a psychiatric holding facility. Prior to the development of this program, epidemiological research indicated that the Indian people of the Shoshone-Bannock tribe had an alarming suicide rate much above the national average. Most of the reported suicides and suicide attempts were among younger people, over half of the episodes involving individuals under twenty years of age. In the seven months following May 1969 that this facility has been in full operation there has been only one reported suicide in the reservation community.

This facility is to serve as the base for additional research, designed to identify the characteristics which place individual patients in a high risk category for self-destructive behavior. The research should give impetus to the development of a mental health program which involves the entire community with helping agencies and consultants. Significant clinical factors could be combined with pertinent historical data to develop a questionnaire that can identify those individuals in the high morbidity group, thus enabling the facility to function more effectively in preventing self-destructive behavior. Records of suicide attempts, the numbe of patient hospitalizations, and individual treatment records can be used to document the effectiveness of the treatment process. The training program and on-job consultations with the indigenous counselor-attendants will be considered as an important aspect of the treatment program. The relative effectiveness of these indigenous counselor-attendants, follow-up social workers, and professional staff can be compared with one another in order to ascertain the most effective components of the treatment process.

In a later publication Dr. Shore summarizes suicide studies of a number of Indian populations, and develops the concept that some tribes and some individuals within tribes are at high risk for suicide gestures and completions. Much of this research draws heavily on data collected at Fort Hall and on other programs stimulated by this early example.

III. FIRST FULL TIME MENTAL HEALTH TEAM 1969

A. James Shore, M.D. and Staff

With the beginning of the Fiscal Year in July of 1969, Dr. James Shore was appointed as the First Chief of Mental Health Services, for the Portland Area of IHS. He shortly recruited the typical components of the traditional Orthopsychiatric team, a Psychologist, Ashley Foster, Ph.D., who also had an MPH degree and considerable experience in teacher training, and a Social Worker, Thelma Ruth Waller, MSW, who was assigned for full time service to the Fort Hall reservation in Southern Idaho, and did not participate in the Area Office activities on a regular and frequent basis.

Dr. Foster's expertise in research and evaluation was seen as potentially valuable to the community agencies and tribal organizations with whom the Mental Health staff would work. Dr. Shore, who shared these interests, was also able to provide the direct clinical services which had proved to be a significant ingredient in the development of the program at Neah Bay. A regular schedule of consultation visits to each of the major Service Units was established, and monthly visits became the goal to be accomplished. Dr. Shore purchased for himself a camper which enabled him to take his wife and small daughter with him. In this way he was able to spend about two days at each reservation, including evening meetings and consultations as well as the activities during normal clinic hours.

The use of Residents in Psychiatry from the University of Washington Medical School to work with the Makah at Neah Bay continued. A similar agreement involving medical students as well as residents was in process of negotiation with the University of Oregon Medical School.

Local psychiatrists in the cities near Fort Hall, Idaho, Yakima and Lummi reservations in Washington and at Salem, Oregon near the Chemawa BIA Boarding School were also encouraged to formalize agreements for Mental Health Services. These agreements and the early and continuing interests they represent were evidence of the continuing support of the IHAD, Dr. Stanley Stitt, for the new Mental Health programs.

B. Consultation Patterns

In the Spring of 1970 the work of the first six months as a formal program was summarized in a formal report by Dr. Shore and Dr. Foster which is quoted below.

AREA WIDE PATTERNS

For each mental health consultation contact in local Indian communities the consultants, Dr. Shore and Dr. Foster, maintained a daily log. This record sheet is included in the appendix. The basic outline for this check sheet was suggested by Griffith and Libo in Mental Health Consultants: Agents of Community Change. The outline has been revised, following its initial use in a consultation pilot project in the Western Washington Service Unit. The daily log includes a record of the type of consultee contacted, the individual who initiated the consultation, type and duration of the contact, primary emphasis of the meeting, referral of the client, and the designee of responsibility for further action. A summary of these daily logs is included in the following section which reports the number and types of contacts on an area wide basis and for individual service units.

The number of individual field visits has been determined by limitations of the consultants' time and the demands in beginning a new program. However, requests from local service units and Indian people have been the primary factors in determining the priorities for mental health consultation in the first five months. The number of individual contacts and the type of consultee reflects both the orientation of the Mental Health Office consultants and the need and interest of local Indian people. One goal of the mental health consultations is to document the consultation process and its evolution over time. This is an initial report which will provide a foundation for this documentation and a basis for comparison of further consultation work. We expect the type of consultees and the focus of individual consultation contacts to change as the mental health program extends into each community and as the consultees become increasingly sophisticated with their involvement.

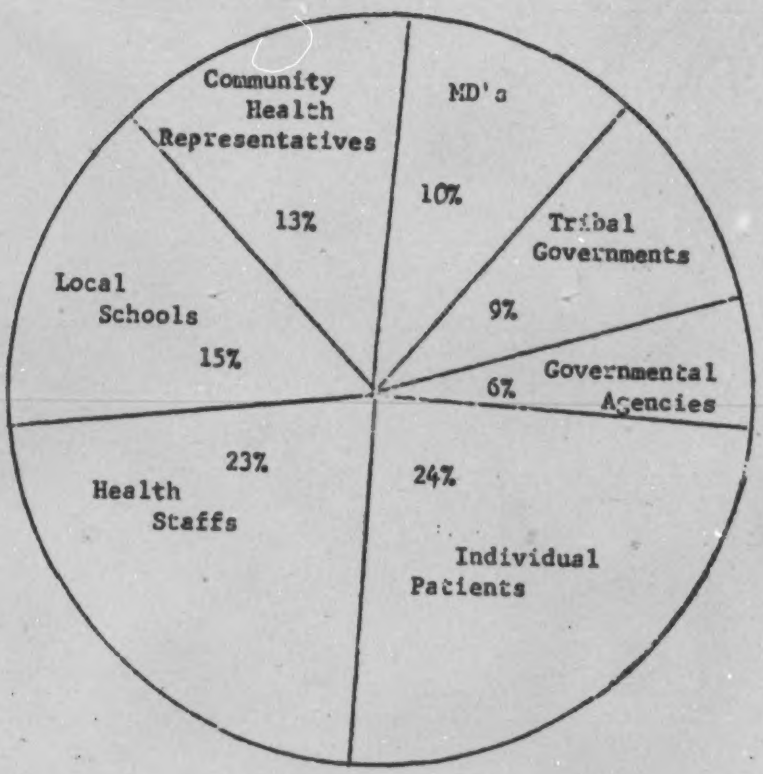
The service unit emphasis plans for mental health consultation were developed through direct planning with each local service unit. They are presented here to provide an outline for consultation planning on each reservation and to serve as goals for the next twelve months. These emphasis plans are only guidelines and should remain flexible, changing to meet the demands and resources of each local area.

The charts on the following pages are intended to present a broad outline of the area wide pattern of mental health consultations, reporting the type of consultees seen and the focus of community consultation. The term "direct" is used to refer to patient consultation. The term "indirect" refers to mental health consultation contacts with other individuals in local communities, including health staffs, tribal governments, community agencies, and others. Chart I reports the percentage of consultation contacts by type of consultee in local Indian communities. Chart II reports mental health field contact by consultation emphasis, as rated by the consultants.

Area-Wide Pattern of Mental Health Consultations

- TYPE OF CONSULTEES -

CHART I

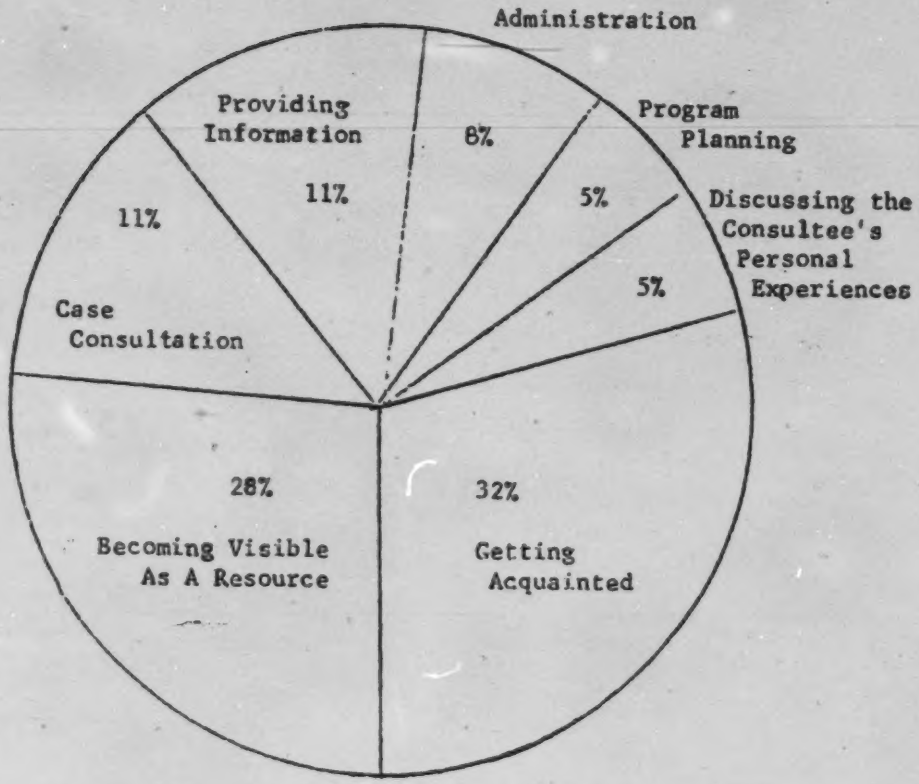


The chart above reports the percentage of consultation contacts by type of consultee in local Indian communities.

Area-Wide Pattern of Mental Health Consultations

- FOCUS OF INDIRECT COMMUNITY CONSULTATIONS -
(direct care-patient consultations
are not included)

CHART II



The chart above reports mental health field contact by consultation emphasis.

MENTAL HEALTH FIELD CONSULTATIONS AUG. - DEC. 1969

LOCATION	NUMBER CONTACTS		TYPE OF CONSULTEES							INITIATION.		
Service Units	Field Visits	Individual	CHR	MD	Patient	Health Staff	School	Local Gov.	Gov. Agency	Consultant	Consultee	Third Party
Chemawa	5	13	-	3	-	5	8	-	1	4	4	5
Colville-Spokane	2	21	2	2	9	3	-	4	-	7	2	14
Fort Hall	5	43	1	1	3	18	-	1	5	11	9	22
Lapwai-Coeur d'Alene	2	11	2	-	-	5	2	3	1	6	1	4
Lummi	1	4	1	1	-	-	2	-	-	2	-	1
Neah Bay	4	35	8	5	16	2	6	-	-	9	10	12
Taholah	4	28	1	6	8	4	8	2	-	11	2	10
Umatilla	2	7	1	-	-	2	2	3	1	3	1	1
Warm Springs	3	34	4	4	9	7	5	6	3	14	8	10
Yakima	2	13	2	1	1	4	-	1	2	5	2	5
Western Washington	3	4	7	-	1	1	1	-	1	8	2	3
TOTAL	33	213	29	23	53	51	34	20	14	80	41	87

MENTAL HEALTH FIELD CONSULTATIONS (continued)

LOCATION	FOCUS OF CONTACT										RESPONSIBILITY FOR FURTHER ACTION				REF.
Service Units	Becoming a Resource	Getting Acquainted	Case Consultation	Seeing Patient	Intraagency Communication	Interagency Communication	Providing Information	Training Programs	Consultee's Experiences	Program Planning	Consultee	Consultant	Both	Third Party	Consultee Referred
Chemawa	10	10	2	-	1	-	1	-	-	1	5	-	6	2	-
Colville-Spokane	10	9	3	8	1	-	1	-	-	-	11	-	5	7	9
Fort Hall	12	10	6	10	6	1	3	2	6	5	16	4	16	11	5
Lapwai-Coeur d'Alene	8	7	-	-	1	1	4	-	-	-	-	2	7	2	-
Lummi	1	3	1	-	-	-	1	-	-	-	-	-	4	-	-
Neah Bay	3	1	3	16	5	1	6	-	6	3	18	3	13	5	4
Taholah	9	15	8	7	2	-	6	1	1	1	9	1	17	5	7
Umatilla	2	5	1	-	-	-	3	-	-	-	2	2	3	-	-
Warm Springs	11	17	5	9	1	-	6	-	-	1	15	5	14	4	1
Yakima	7	9	1	2	1	-	-	-	-	-	5	2	6	-	-
Western Washington	7	5	3	-	2	1	2	-	2	-	2	1	10	1	2
TOTAL	80	91	33	52	20	4	33	3	15	11	83	20	101	37	28

It is interesting to compare the information about consultation contacts and the proportions of time spent in delivering direct patient care with that spent giving consultation to caretakers within and outside IHS. It is particularly striking that 60% of the time in the first year is spent in getting acquainted on the various reservations and in becoming visible as a resource to the tribes and the other staffs already serving them. This seems rather a long period of introducing services compared with the Neah Bay report on the anatomy of a psychiatric consultation program, until one realizes that the Neah Bay program allowed two professionals each to spend two or three full days per week on the reservation. The Area program permitted staff travel to each Service unit not oftener than once a month, which spaces out both the availability of the source, and the opportunities for being inducted into the life of the Reservation over a longer calendar period.

Comment:

The logs of patients seen and the analysis of the problems presented to consultants were not only utilized in this study but also became the raw data from which recommendations were later made for recordkeeping and report form design for IHS Mental Health and Social Service. These studies share an interest in epidemiologic factors with an earlier study in which Dr. Shore participated entitled "Psychiatric Epidemiology of an Indian Village" (Shore,J. , Kinzie, J., Hampson, J., and Pattison, E.M., Psychiatric Epidemiology Research Review, 8: 195: 195-198, Oct. 1970.)

The Epidemiology study of an Indian Village was conducted by individuals who did not have as much pressure to deliver services as IHS staff and employees. They were able to seek out and evaluate persons not normally seen by IHS and therefore be fairly certain that their reports were not biased by population samples limited to known patients.

IHS program planning in general and its Mental Health programs in particular have great need for this type of information on a wider scale. There is also a need to be able to adapt programs and procedures to the findings of such research efforts. (A process easier to espouse than to implement in any Bureaucracy.) The report just quoted is a parallel effort to develop what might be called an "Epidemiolgy of Mental Health Consultation." Both types of activity are needed.

C. Objectives Established

It might be noted that in establishing the Area-wide program the modes employed incorporated the model described for Neah Bay, and also the model of autonomously functioning Indian administered and contracted programs developed at Fort Hall. This is perhaps a natural consequence of carrying out the Neah Bay model to its logical conclusions,but it is not always as clear as this. Mental Health Staff in other Areas are not always willing to follow out these intentions in developing programs at the local level.

Many factors enter into the accomplishment of this goal:

The ability to define specific services for which contracts can be written;

The readiness of tribal groups to assume the responsibility of direction and control for themselves;

The availability of sufficient professional resources for 'back-up' services both within IHS and in the surrounding Indian and non-Indian communities.

Each of these necessary elements accounts for the varying degrees to which the goals are accomplished. The objectives established for each of the Service Units in the first year of the mental health programs operation and the actions to be taken to achieve them give a fairly accurate picture of the initial status of mental health programs throughout the area. They are therefore copied from the report on the first 6 months activity previously cited.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

CHEMAWA

OBJECTIVES

1. Establish consultation relationship with school administration and teaching staff.
2. Case consultation with field BIA social workers, concerning boarding school condidates.
3. Supplement consultation of contract psychiatrist when requested. (Dr. Jetmalani)
4. Program planning consultation.

ACTION STATEMENTS

1. Field visit to meet with teachers and school administration. Followed by monthly mental health seminar with the teacher supervisors.
2. Initial contact with BIA field social service staff. (done at Fort Hall, Umatilla, Lapwai, Warm Springs--incomplete at Western Washington, Yakima and Colville. Pursue BIA contacts with casework consultation when requested.
3. Consultation with clinic staff, students, social service, and dorm counselors. Provide inservice training to staff on request.
4. Assist in development of "Petroleum Inhalant Abuse Survey" and a treatment program for this population.

TARGET DATE
July '69 - Dec 70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the Mental Health Team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

COLVILLE - SPOKANE

OBJECTIVES

1. Become more visible as resource on Colville and Spokane Reservations.
2. Supportive consultation for developing new Colville CHR - alcohol caseworker program.
3. Consultation services to clinic staff: instaff training and direct patient services.
4. Mental health resource seminar, involving tribal leaders, clinic staff, BIA, and community resources for Colville and Spokane tribes.
5. Definition of extent and types of mental health problems.
6. Consultation with CHR and tribal police from Spokane Reservation.

ACTION STATEMENTS

1. Regular consultation visits by Dr. Shore.
2. Regular meetings with tribal council and CHR supervisor. On-site training.
3. Staff training sessions and "open-door" consultation clinic, by mental health team and/or outside psychiatric consultant.
4. Explore interest in Mental Health Resource Seminar with tribe and clinic staff.
5. Consider epidemiological survey.
6. Periodic consultation meetings with these personnel.

TARGET DATE
July '69 - Dec. '70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the Mental Health Team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

FORT HALL

OBJECTIVES

1. Expand medical holding facility to include broader range of mental health services.
2. Increase mental health awareness and communication of clinic staff.
3. Mental Health Resource Seminar, involving tribal leaders, clinic staff, BIA, community resources, including ISU & VISTA.
4. Coordinated mental health effort with IHS social service.
5. Improved skills of counselor-attendants.
6. Increased awareness local police of mental health problems.
7. Increased sensitivity of local schools to problems of acculturation.
8. Coordinate Mental Health effort with VISTA education program.

ACTION STATEMENTS

1. Consultation for grant with SUD, psychiatric social worker, and NIMH.
2. Instaff training focusing on emotional and cultural aspects of patient care, "direct care" with patient consultation in liaison with local psychiatric consultant (Dr. James Martin).
3. MHRS planning with tribal leaders and clinic staff (Mental Health Resource Seminar).
4. Regular meetings with psychiatric social worker.
5. Training seminars on care of suicidal patients.
6. Monthly seminar with Blackfoot police.
7. Contact school personnel and Indian education coordinator.
8. Consult with VISTA on pre-kindergarten program.

TARGET DATE
July 69 - Dec. 70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the mental health team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

LAPWAI - COEUR D'ALENE

OBJECTIVES

1. Effect a change in pattern of petroleum inhalant abuse among younger adolescents.
2. Mental Health Resource Seminar, involving tribal leaders, clinic staff, BIA, community resources.
3. Acquaintance with tribal leaders and health committee at Lapwai.
4. Familiarization with state resources.
5. To increase the sensitivity to mental health problems by health staff.

ACTION STATEMENTS

1. To meet with clinic staff, school counselors and administrators in a planning group.
2. Seminar planning with tribal leaders and clinic staffs, at Lapwai and Coeur d Alene.
3. Request SUD to schedule appropriate contacts.
4. Visit state hospitals.
5. Consultation with SUD and CHR's from Lapwai and Coeur d'Alene.

TARGET DATE
July 69 - Dec. 70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the mental health team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

LUMMI

OBJECTIVES

1. A clearer definition of mental health problems and program needs.
2. Become familiar with local alcohol treatment group.
3. Liaison in education consultation with local schools.
4. Consider Mental Health Resource Seminar, involving tribal leaders, clinic staff, BIA, schools, local mental health clinic, community and state resources.
5. Definition of drug abuse problem on the reservation.

ACTION STATEMENTS

1. Consultation with MD, tribal leaders, and community agencies to establish an outline of mental health patterns.
2. Visit with AA leaders.
3. Contact Director of Project Catch-up, WWSC.
4. Explore interest in mental health resource seminar with clinic staff and tribal personnel.
5. Drug abuse survey (consider medical student fellowship as one possible personnel resource for such a survey).

TARGET DATE
July '69 - Dec. '70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the mental health team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

NEAH BAY

OBJECTIVES

1. Continue consultation with clinic staff and CHR's. Liaison with resident psychiatric consultant.
2. Reinforce roles of CHR's in school counseling and school program planning.
3. Increased sensitivity of mental health problems by tribal leaders and community groups.
4. Stimulate development of reservation based foster homes.
5. Pursue investigation of high prevalence of active peptic ulcers.
6. Mental health resource seminar, involving tribal leaders, clinic staff, CHR's, BIA, school community and state resources.

ACTION STATEMENTS

1. "Open door clinic." Individual consultations with MD and CHR's. Monthly contact by consultants with visiting psychiatrist (Dr. Mollerup) in Seattle or Neah Bay.
2. School consultation with CHR. Meet with Makah Alcoholism Committee.
3. Meetings with chairman of health committee, tribal council, and law enforcement.
4. Consultation in proposal development, in conjunction with Area Office pediatric consultant.
5. Survey of medical records with MD. Consider use of special G.I. consultant.
6. Pursue plans with Olympic Center in Bremerton to sponsor this seminar for Neah Bay, Taholah, and small local tribes.

TARGET DATE
July '69 - Dec. 70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the mental health team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

TAHOLAH

OBJECTIVES

1. Increase awarness of health clinic staff to mental health problems and resources

2. Assistance in planning mental health programs.

3. To provide liaison in educational consultation to local school.

4. To provide consultation in developing the special education unit at Neah Bay High School.

5. Mental health resource seminar, involving tribal leaders, health committee, CHR, BIA, school, community and state resources.

ACTION STATEMENTS

1. Consultation with clinic staff in group and individual sessions. "Open door clinic" for patient evaluation and treatment.

2. Conjoint planning with the tribal health committee, CAP, and SUD.

3. Meet school superintendent. Work with CAP educational consultant.

4. Regular consultation with school staff working with the special unit.

5. Pursue plans with Olympic Center in Bremerton to sponsor this seminar for Taholah, Neah Bay, and smaller local tribes.

TARGET DATE
July 69 - Dec. 70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the Mental Health Team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

UMATILLA

OBJECTIVES

1. To facilitate use of Indian OEO education counselors in work with invividual Indian students in the schools.
2. To stimulate discussion and tribal involvement in an alcohol treatment program.
3. Increase mental health team's awareness of local resources.
4. Support mental health work and planning of service unit and tribal personnel.
5. Mental health resource seminar, involving tribal leaders, health committee, service unit staff, BIA, and community resources.
6. Increase consultation services to Indian students applying for boarding school placement.

ACTION STATEMENTS

1. Offering case consultation to education counselors. Providing liaison with school administration.
2. Conjoint meeting of interested persons to discuss planning for alcohol treatment program, scheduled by SUD.
3. Field visit to local mental health clinic and state hospital.
4. Consultation with SUD, CHR's, and tribal health committee.
5. Explore interest in mental health seminar with tribal personnel and SUD.
6. On request, consult with BIA community services field worker.

TARGET DATE
July '69 - Dec. '70

RESOURCE REQUIREMENTS
Field consultation by one or both members of the mental health team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

HARM SPRINGS

OBJECTIVES

1. Increase awareness of health clinic staff to mental health problems and resources.
2. Support planning for Alcohol Abuse Treatment Program.
3. Liaison in educational consultation with local schools.
4. Coordination with local Mental Health Clinic.
5. Mental Health Resource Seminar, involving tribal leaders, health committee, CHR, BIA, schools.
6. Support mental health involvement of CHR.

ACTION STATEMENTS

1. Consultation with clinic staff in group and individual sessions. "Open door clinic" for patient evaluation and treatment.
2. Consultation with planning committee.
3. Meet school administrators and counselors.
4. Attend Tri-County Health Clinic meeting in Bend.
5. Explore interest in mental health resource seminar with tribal personnel and clinic staff.
6. Regular individual consultations with CHR.

TARGET DATE	RESOURCE REQUIREMENTS
July '69 - Dec. '70	Field consultation by one or both members of the mental health team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

YAKIMA

OBJECTIVES

1. To supplement and continue ongoing mental health consultation with clinic staff.
2. Act as consultants to tribal education committee.
3. Support work of tribal alcohol program planning committee.
4. To increase awareness for potential of developing an "Indian Alcohol Abuse Treatment Program" at the Sundown-M Ranch
5. Mental Health Resource Seminar, including tribal leaders, clinic staff, BIA, and community resources.
6. To provide a psychiatric evaluation and follow-up for suicide attempts and threats.
7. To provide consultation to public welfare group and CHR's.
8. To provide consultation to BIA social service.

ACTION STATEMENTS

1. Consultation sessions with staff, structured by SUD. Liaison with Dr. Pattison by meetings in Yakima and Seattle. "Direct care" through patient consultation.
2. Liaison for tribal leaders with public schools, consultation planning meeting with school counselors.
3. Attend a committee meeting, coordinated by Mr. Gaulke.
4. Work with Sundown-M staff to develop program for Indians.
5. Seminar planning with clinic staff and tribal leaders.
6. Seminar with "suicide helpers" (community gatekeepers), health staff, and Dr. Pattison.
7. Consultation by Dr. Pattison.
8. Consultation offered by Drs. Shore and Foster.

TARGET DATE

July '69 - Dec. '70

RESOURCE REQUIREMENTS

Field consultation by one or both member of the Mental Health Team on 4-8 week schedule.

SERVICE UNIT EMPHASIS PLANS FOR MENTAL HEALTH CONSULTATION

PORTLAND AREA OFFICE

OBJECTIVES

1. Coordination of the Mental Health Office and the Social Service Office in the development of mental health programs.
2. Coordination with Dr. Jean Goorman, Field Medical Consultant, in area of maternal and child care.
3. Increase awarness in the Area Office staff of the emotional needs of th field medical personnel.
4. Working liaison with the Bureau of Indian Affairs, Portland Area Office.
5. Increased awarness of the mental health perspective in program planning at the Area Office level.
6. Provide resource of mental health educational and referral material.
7. Provide a focus for the planning and coordination of "research-service" projects.

(continued on following page)

ACTION STATEMENTS

1. A mutual review of existing alcohol treatment facilities with consideration for the appropriatness of individual facilities in developing an Indian alcohol abuse treatment program.
2. Planning and support for Indian people to facilitate the development of reservation based Indian foster homes.
3. Appropriate feedback to the Area Office staff from field station consultation.
4. Regular meetings with B.I.A. Educational and Social Service Supervisors.
5. Participation in Area Office program planning meetings.
6. Develop a Mental Health library available to Area Office and service unit personnel.
7. Participation in the Area Office research committee by Dr. Shore.
   Consultation by Dr. Foster on proposed research from service unit stations.
   Coordination with outside research personnel who may be developing a program on a particular reservation.

(continued on following page)

TARGET DATE
July '69 - Dec. '70

RESOURCE REQUIREMENTS
Mental health consultants

Portland Area Office Emphasis Plan

continued

OBJECTIVES	ACTION STATEMENTS	TARGET DATE	RESOURCE REQUIREMENTS
8. To coordinate and stimulate development of outside mental health consultants for local Indian Health field stations.	8. Coordination with Dr. Pattison in Yakima, Dr. Jetmalani in Chemawa, Dr. Martin at Fort Hall, and Dr. Mollerup at Neah Bay to continue these existing consultations.	July '69 - Dec. '70	Mental health consultants
9. Area Office Consultation with Chief of the Pharmacy Office.	9. To provide mental health consultation to the pharmacy officers at local field stations for the development of drug abuse surveys, patterned after the Fort Hall pilot project.		

D. Special Projects

1. Foster Homes for Indian Children

In addition to the special program developed for suicide prevention at the Fort Hall Service Unit, a number of other special program emphases were identified. One of these, the need for Indian Foster Homes for children whose homes were disrupted or whose parents were too ill to care for them has developed into a national concern that was the subject of Senate Hearings in the spring of 1973. Since the substance of these hearings was the opportunity for many Indian people as well as professionals to present their findings and opinions, it is instructive to see the report of efforts by the Mental Health Programs staff to assist in the implementation of the development of appropriate state action in 1969. The following is taken from the Area report by Shore and Foster previously cited.

FOSTER HOMES

Among many of the tribal groups with whom we work, there has been expressed a strong interest in the development of reservation-based foster home facilities for Indian children. This is and has been a serious concern to many tribes who have objected to local court placement of Indian children in non-Indian foster homes. This, they feel most keenly, leads to an environment in which many Indian children will lose their Indian identity.

Upon request we have initiated a renewed effort to meet with the Branch of State Child Welfare concerned with foster children. Proper foster home placement can have a distinct relationship to the psychological adjustment and the mental health of Indian children. In many cases, we feel, it is probably better for the mental health of the Indian children to be in Indian homes in their own community than in non-Indian homes, even if this requires a change in the existing foster home licensure standards. In relation to the Indian homes available, foster home standards tend to be unrealistic.

Working with the Maternal and Child Health and Social Service Offices of the Indian Health and appropriate state agencies, we hope to encourage the initiation of tribal action in the development of licensable homes on the reservation. We hope that such action will serve to increase the number of such homes and will generate greater interest on the reservation in carrying out activities which will stimulate a greater participation in foster child care.

SAMPLE RESOLUTION ON FOSTER HOMES

The following is a resolution of a Northwest tribe, expressing their feelings about foster home placement for Indian children:

WHEREAS, the Tribal Executive Committee has expressed its concern regarding state policies on foster homes and adoption of Indian children; and

WHEREAS, many Indian children tend to lose their true identity and their Indian heritage as well as being displaced from their family and blood relatives who are known to be or determined to be responsible and reliable persons in raising a family; and

WHEREAS, it has been noted over the more recent years that there has been an increase in interest in providing foster homes for Indian children and adoptions by non-Indians, especially since initial per capita payments have been distributed to tribal members.

NOW, THEREFORE, BE IT RESOLVED, that the Tribal Executive Committee hereby re-affirms its position in opposition of over looking such Indian families by providing foster homes in non-Indian families.

BE IT FURTHER RESOLVED, that the adoption out of Indian children to non-Indian families is hereby opposed.

RESOLVED, that the appropriate state agencies and the office of the Governor is hereby respectfully requested to give every favorable consideration in providing foster homes for Indian children with Indian families or the adoption thereof, by Indian families be given priority and that any state policies made contrary thereto, be made flexible with regards to Indians.

2. Peptic Ulcer Study of Makah Tribe

An epidemiologic survey carried out while Dr. Shore was one of the residents serving at Neah Bay indicated a high prevalence of Peptic Ulcer, and especially a reversal of the national trend for men to be more often patients for this disease than women. This study was continued under the contract arrangements, and a carefully conducted survey of both men and women in the villages was made to determine the actual rate of incidence. Examination of medical records and interviews were conducted by the University of Washington Medical School staff and Residents.

Although the initial survey indicated a ratio of 1:3 for men to women, a careful study of medical records reduced the ratio by finding it to be 1 man to 1.5 women. However, women made more use of the IHS medical staff during and between episodes, while men only utilized the physicians at the time of acute distress or dramatic symptoms. The rate for occurrence in the Makah Reservation was established at 5% of the population, significantly higher than the national average of 3%, and the prevalence for women at about 4 times the non-Indian average.

These findings were discussed with the medical staff, and with the tribal leaders and CHR's. Interestingly enough the pattern is not unlike that of the early 19th Century, when women tended to be chief sufferers in the Northern European population. It may also be found in other localities where matrilinear responsibilities are producers of intense stress in the transition from traditional to industrial cultures, and are compounded

by poverty and social disorganization. Much of the solution seemed to be in getting at root causes, and in sensitizing the medical personnel so that early case finding and adequate follow-up patterns could be established.

The results of this study are summarized in a paper prepared by Dr. Shore and Dennis L. Stone, a senior medical student at the University of Oregon Medical School in 1970. This paper entitled Duodenal Ulcer Among Northwest Coastal Indian Women was published in the American Journal of Psychiatry 130:7, 1973, pp. 774-777. In this report the authors are careful to point out that along with dietary and socio-cultural factors, genetic elements must also play a role, since the findings are diametrically different from those of M.L. Sievers in studies of another tribal group in the Southwestern United States.

3. Sensitivity of Mothers and Adolescents to Preventive Health Care

In cooperation with Maternal and Child health as well as with the physicians in general medical services, the research expertise of the mental health staff was utilized in preparing a survey concerning the perceptions of the two large groups in the population, Mothers of small children and Adolescents themselves. The surveys were designed to tap awareness of preventive as well as treatment health routines, and aspirations for standards of optimal health, as well as attitudes toward IHS and other surveyors of health care services. No follow-up report of this study has been provided. Since it had major relevance for other programs as well as mental health, it has been absorbed by these branches of IHS after the initial planning consultations.

4. Alcohol Abuse Treatment Planning

Characteristically the planning for program development in this major area of mental health concern involved Indian participation and liaison with tribal alcoholism programs. However, definite roles were seen for both Mental Health staff and for IHS service units as a whole. The description of the plans to be implemented from the 1969 report to the Area Director sum up this position well, and forecast activities in the years to come.

ALCOHOL ABUSE TREATMENT PROGRAM

Because of the existence of alcohol abuse as a major Indian Health problem and repeated requests for assistance in the planning of an alcohol treatment program from members of tribal government, the Mental Health Office has placed high priority on development of an alcohol abuse treatment program for Indians of the Pacific Northwest. The extent of the problem of alcohol abuse on a national scale is outlined in the "Preliminary Report of the Indian Health Task Force on Alcoholism" of January, 1 69. One local perspective of the extent of this problem is recorded in "Psychiatric Epidemiology of An Indian Village" from the Department of Psychiatry of the University of Washington by Drs. Shore, Kinzie, and Pattison.

We feel that as an immediate goal, we should establish a comprehensive program for the treatment and diagnosis of alcoholic patients with the organization of an effective follow-up program in cooperation with multiple agencies in all Indian Health facilities and establish an Alcohol Program Officer as a member of the mental health team, to coordinate the alcoholism program. This is in line with the recommendation of "The Preliminary Task Force" report.

Five principles are considered to be outstanding and shared in common with existing Indian alcohol treatment programs in other sections of the country. Including these principles, a comprehensive program should:

1. be an all Indian program with emphasis on community involvement at the local level.

2. utilize the principles of Alcoholics Anonymous, but adapted to the special characteristics of the Indian culture and broadened to include an educational emphasis on the effects of alcohol abuse for the entire community, particularly the youth.

3. be developed with reservation-based Indian alcohol case workers.

4. share specific area-wide resources, such as:

   a. two alcohol program officers.

   b. a central inpatient treatment facility for acute withdrawal and initial rehabilitation (the "initial treatment center").

   c. shared resources of professional consultation.

   d. regional training labs for helping personnel.

   e. standardized evaluations of the effectiveness of the treatment program, leading to the evolvement of more effective intervention.

5. have a strong emphasis on the development of reservation based, follow-up, treatment programs, structured to meet the needs of local areas and to utilize local resources. With:

   a. participation of a local citizens alcohol planning committee in the development of each program.

   b. regular long-term individual follow-up by alcohol case workers. (non-drinking alcoholic)

   c. reservation halfway houses (if appropriate to the needs of the local area).

   d. vocational rehabilitation.

   e. a working relationship with courts and the parole system.

An area wide planning conference to assist in the development of an Indian alcohol abuse treatment program, founded on the above principles, is under consideration in the Mental Health Office. Such a planning conference should include directors of the existing Indian treatment programs with an opportunity for Northwest Indian representatives to meet with these directors and to learn of their work. Initial discussion of the possibility of a planning workshop has met with enthusiastic reception from Indian people of the Northwest.

5. Groundwork Laid in 1969-70 For Use of Mental Health Workers

During the early phases of the development of mental health programs in the Portland Area, IHS had utilized non-Indian national VISTA volunteers in many of its outreach and local programs. The model of paraprofessional staff, recruited and trained specifically for mental health tasks evolved naturally from this experience. It proved to be quite successful on the Fort Hall Reservation. This was a somewhat different base from which to approach the use of Mental Health workers than in other Areas where local Indian employees expanded their roles. Perhaps in other Areas interpreters were more often needed, or clerical positions were more available to be utilized as an entry into more extensive counseling through the redefinition of duties for receptionists. The CHR's and local alcoholism counselors also provided role models in the Portland Area for the use of paraprofessionals with mental health skills. Although Mental Health Workers were added during the first year of operations, the groundwork was laid for recruiting and training these personnel once budget and career ladder job descriptions could be developed.

6. Other Activities In The First Year

A number of other activities were also carried out during this initial year. Seminars for community agencies and tribal personnel, participation in larger meetings for Tribal Leaders, University and Medical Students, Educators and Public Health personnel were all part of the daily attempts to gain visibility as a resource and to become acquainted in the three state Area.

Record keeping, and the establishment of patient registers, especially for suicide attempts and suicides completed was also a significant activity initiated in this period and carried on to bear fruit in subsequent years.

7. Look to the Future

The final parapraphs of the 1969 report summarize the main thrusts foreseen for the future, as well as the immediate needs for personnel to implement them.

FUTURE DIRECTION AND PROGRAM GROWTH

As a comprehensive mental health program for Northwest Indian people develops, there will be an additional need for human and financial resources. Guidelines for future growth are provided in the emphasis plans for individual service units and in the description of special projects. A coordination of local, state, and federal support will be an essential part in taking advantage of all potential resources available for mental health.

The Mental Health Office has an immediate need for a third, full-time Area Office consultant who can carry on the field consultation work with Dr. Shore and Dr. Foster. This third person could come from the fields of psychiatry, psychology, social work, or mental health nursing. The individual should be capable of providing direct clinical service for individual patients and community consultation in local reservation areas. At the same time the Mental Health Office will attempt to stimulate psychiatric consultations for larger service units from private psychiatrists in an effort to provide Indian Health clinics with additional, regular, monthly consultation. This will supplement the work of the Area Office consultants and be carried on in parallel. Private psychiatric consultants are presently working in this relationship in four service units.

The Mental Health Office plans to develop an indigenous mental health associate program as described under Special Projects. These mental health associates would be full-time employees of Indian Health, stationed at local Indian communities. At present, resources are not available to begin this program. A position for two alcohol program officers for the Pacific Northwest is also under discussion and included in a proposal which is pending at the National Institutes of Health. These officers could work closely with the Mental Health Office in developing a comprehensive alcohol abuse treatment program for Indian people.

IV. PROGRAM DEVELOPMENT 1970-72

A. Staff

1. Increase in Professional Staff

During the next two years the Portland Area Mental Health programs were characterized by expansion of staff and continuing development along the lines described in the original planning. Ms. Billie Von Fumetti, MPH, a nurse who had received a Mental Health Career Development Fellowship, joined the Portland Area staff. By the end of this time period (1972) Ms. Von Fumetti was designated Deputy Chief, as well as having earned a special citation for her work in program development. Dr. Ashley Foster, whose psychological training was more in research than in clinical and consultation services transferred to the Area Office of Program Planning and Evaluation. His place on the Mental Health team was filled by Rosalie Howard, Ph.D., a psychologist who transferred from the Navajo Area.

With a team of three professional persons, each capable of delivering both consultation and clinical services, the Area Office load was redistributed. By December 1971 each of the Area staff assumed responsibility for consulting with specific reservations: Dr. Shore concentrated on the Warm Springs, Yakima and Colville Reservations, and was able to visit each on a monthly basis.

Ms. Von Fumetti became responsible for the reservations in Northwest Washington: Quinault, Quileute, Makah, Swinomish, Tulalip, Lummi and STOWW.

Dr. Howard assumed responsibility for newly emerging programs at Umatilla, Washington, and the Northern Idaho Service units of Nez Perce, Coeur d'Alene, and Kootenai. She also shared responsibility for consulting to Fort Hall with Dr. Shore.

Since even this tripling of staff was insufficient to keep pace with the widely developing interest in utilizing mental health services, contracts were negotiated with six psychiatrists in private practice for service to five specific reservations: Lummi, Swinomish, Tulalip, Yakima, Taholah, Shoshone Bannock (Fort Hall) and to the BIA school at Chemawa.

Mr. Gualke, MSW, from the Social Services Branch continued his active role at Yakima. In addition the contract with the University of Washington Medical School continued to provide a psychiatry resident to the Makah Reservation at Neah Bay even though Dr. Mansell Pattison under whom these arrangements originated had moved to Southern California. A University of Oregon program parallel to this began, providing a child psychiatry resident to work with a tribal child care program at Warm Springs, Oregon.

Mr. John Bopp, MSW, the former Service Unit Director at Fort Hall transferred to STOWW in the spring of 1972, and initiated regular consultation services to Lummi, Swinomish and STOWW on a weekly basis, providing professional services and consultation to Service Unit staffs which supplemented the Area Office consultations.

In addition to Mr. Bopp, two other social workers were added on locations at various reservations. They are briefly described in the Area report to the IHAD dated February 1972.

Mr. Tom Keast, Psychiatric Social Worker, joined the Mental Health Office July 1, 1972. He served as Service Unit Director and Social Worker at Chemawa Indian School for the 1972 Fiscal Year. Prior to his employment in the Portland Area he worked for Indian Health Service in the Billings Area. During that time he received a special commendation for his efforts in coordinating resources and for exemplory leadership in providing health services to Indians on the Flathead Reservation. Mr. Keast will be responsible for the development of a mental health program at the Northern Idaho Service Unit in Lapwai, Idaho.

Mr. Ted Kammers is the new psychiatric social worker at Taholah, Washington. He assumed his duties on May 28, 1972. Mr. Kammers has had extensive field experience in the Bureau of Indian Affairs and Indian Health Service in social work administrative and supervisory roles. He worked in Alaska for five years prior to his position with IHS Social Service on the Colville Reservation. Mr. Kammers will continue the development of the mental health program for the Quinault Reservation.

2. Development of Cadre of Mental health Workers: 1970-72

Starting with three paraprofessionals in 1970-71, six additional Mental Health Workers were recruited by 1972. This addition to the total staff of the mental health program increased the resources of the Service Units and added depth and breadth to local programs. Each of these Mental Health Workers had specialized interests and duties which were described in the 1972 Area report. These descriptions, rearranged to group the personnel of each service unit together, are quoted below:

Neah Bay

Ms. Donna Grosz has developed her mental health program in Neah Bay with a special interest in preventive work with high school students. She coordinates local and state resources for patients, works with the local Community Health Representatives and others in the community to provide comprehensive care to Indian patients. During the past year she has participated in a training program sponsored by the Harborview Mental Health Center at the Harborview Hospital. Her training experience included in-take counseling, individual therapy, group therapy, and observation of the consultation process with special projects and community organizations. In-patient care included observation of milieu therapy and the emergency service. She is currently responsible for the supervision of a VISTA community mental health worker, for which she received additional training.

Colville

Ms. Josephine Marcelley, Mental Health Worker on the Colville Reservation, brought to her job a varied background in experience and training. She has continued to develop her skills as a therapist and is highly thought of by local tribal groups. Ms. Marcelley attended the University of Utah's Western Region Indian Alcohol Training Center and has nearly completed her field work for final certification. The University of Utah's training program has provided her with many additional skills as a therapist in providing direct patient care.

Ms. Lena Wilson assumed her duties as administrative clerk for the mental health program on the Colville Reservation December 12, 1971. In the past she has worked for IHS, Colville Confederated Tribes and the Bureau of Indian Affairs in a variety of clerk-typist positions. She works under the direction of Ms. Nancy Jo Melise, MSW. Ms. Wilson's main area of responsibility is maintaining the clerical and administrative functions of the mental health and social service programs.

Umatilla

Mr. "Terry" Farrow from the Umatilla Reservation has an exceptional background as case worker prior to his employment with Indian Health Service. Mr. Farrow's major emphasis was on the coordination of local and state resources for Indian patients. In this role he has provided an outstanding service. He has been instrumental in developing a proposal for a community mental health center, developed interest and support for a proposed foster care group-home on the reservation, worked on tribal committees to fund a tribal alcohol and drug abuse program, coordinated efforts with the CHR program, and served as program director of the VISTA Community Mental Health Worker Program. He is currently supervising the Umatilla tribal VISTA worker.

Fort Hall

Ms. Eula Peyope joined the program as a mental health worker on July 24, 1972. She has had extensive experience since 1952 in working with patients as a nurse's aide, community health representative, and tribal mental health worker. Her training background included CHR training at Desert Willow, LPN training at Bingham Memorial Hospital, an Indian Management Institute in 1968, and training in community development in 1969. She will work under the direction of Ms. Thelma R. Waller, ACSW, Psychiatric Social Worker, in the mental health program at Fort Wall, Idaho.

Ms. Roserine Martin, Mental Health Worker, also assumed a position with the program on July 24, 1972. For the past two years Ms. Martin has worked as a mental health worker for the Shoshone-Bannock tribe under the supervision of Ms. Louella Hutchinson. In this role she had regular interviews with patients and family, provided follow-up care, coordinated exisint resources, and maintained individual case records for each patient. She completed LPN training in Blackfoot, Idaho and at the Bingham Memorial Hospital. Her work in the Indian Health Service Mental Health Program will be under the direction of Ms. Thelma R. Waller at Fort Hall.

Yakima

Mr. Fred Martin assumed his duties as a mental health worker on the Yakima Reservation March 13, 1972. He is working under the immediate supervision of Dick Gaulke who is the Yakima Social Worker of the Indian Health Service Social Service Office. Previous to his employment with Indian Health Service, Fred worked for two years with the Community Action Program on the Yakima Reservation. His currect project is with Indian youth in the NYC summer program working on Indian "identity" and self-concept issues. During the coming year he will continue to focus his program on school age children.

Mrs. Dolly Tahsequah has been the mental health secretary at the Yakima Service Unit since February of 1972. She worked as a tribal employee for the MCH program for one year before employment with Indian Health Service. She works under the direction of Mr. Dick Gaulke. Her primary responsibility is keeping the mental health and social service records up to date.

Northern Idaho

Mr. Robert Francis, Mental Health Worker, started his duties on August 6, 1972. His past work has included a position with BIA Social Service includidg a special interest in individual and family counseling. He will work with Mr. Tom Keast in the development of a mental health program for the Northern Idaho Service Unit.

Lummi

Mr. Vendean "Buck" Washington's position as mental health worker for the Lummi Reservation started on July 24, 1972. Mr. Washington's previous experience was in the area of alcoholism counseling. He worked to establish a half-way house and an alcoholism anonymous group on the Lummi reservation. He is well known among the tribes of western Washington for his work with community alcohol programs. Mr. Washington is currently enrolled at the University of Utah's Western Region Indian Alcoholism training course. As a mental health worker he will continue his work in alcoholism and enlarge the scope of his mental health activities as his program develops."

3. VISTA Community Mental Health Workers

In addition to IHS Mental Health Workers, who were all local Indian personnel, seven reservations took advantage of an opportunity to employ community mental health workers through a VISTA project. The Portland Area Office sponsored training and coordination of these volunteers while they were assigned to local programs.

VISTA Community Mental Health Workers

The Mental Health Program sponsored a program proposal for tribal VISTA workers with the Seattle Region X Office of ACTION/VISTA. The purpose of the program is twofold, first to provide tribal groups with the opportunity to define jobs within the community that are needed but not being filled by other agencies, and second to provide Indian paraprofessionals an opportunity for training and job experience allowing them to move up a career ladder to more advanced positions.

The project was funded in December of 1971. All tribal groups were informed of their eligibility to apply for one or more VISTA workers. All VISTA's were selected from within the Indian community by the tribal council or health committee. Job descriptions were written by the tribal health committees serving as a local VISTA Advisory Board and in keeping with the priorities of program development for each reservation community. All VISTA's are under the general supervision of the health committee which develops guidelines and policy for supervision of the local VISTA's. Supervisors range from IHS mental health workers, tribal alcohol counselors, community health representatives to social workers.

Nine VISTA's were recruited from seven reservations. All VISTA's were requested to attend a two week pre-service workshop in Portland, Oregon designed and staffed by the Mental Health Program.

Supervisors were included in the training sessions for three days during the final week of training. On-the-job training schedules were developed by the VISTA's were their supervisors. The on-the-job training period was for a two week period on local reservations.

A follow-up training meeting was held in Portland, Oregon for the VISTA's after they had been on the job for a month and a half. The Mental health area staff provides monthly consultation to VISTA workers and their supervisors. Monthly meetings are held with ACTION/VISTA and Mental Health area staffs to coordinate the VISTA project.

B. Special Programs and Projects

1. Chemawa Boarding School

A number of special projects have developed at the Chemawa Indian High School near Salem, Oregon. There has been an outstandingly good relationship between IHS Staff and BIA staff at this boarding school. Several factors undoubtedly enter into making this relationship viable. One is the high proportion of students that attend the Chemawa School from the reservations in the Portland Area. This enables follow up of dropouts and also pre-planning for entrance to a degree that is not possible in other BIA schools where students do not originate in the Area where the schools are located.

A study to identify potential dropouts, and some structural reorganization of school staff and dormitory assignments as well as an in-service training program are designed to not only collect more accurate epidemiologic data around the problem of school leaving, but also to introduce constructive preventive changes into the operation of the school.

Another factor is probably the long term service of Dr. Jetmalani, a local psychiatrist who consults with the Chemawa BIA and IHS staffs on an IHS contract basis. Dr. N.B. Jetmalani, who came to the U.S. from India, has a real sensitivity to the many problems of individuals at the school, as well as the accumulated experience of several years work in this setting.

A third factor has been the unusual willingness of the BIA school staff to allow the development of student responsibility and participation in developing programs. This is particularly true in relation to the alcoholism program developed through NIMH and NIAA sponsorship. The most complete description of this program is contained in the original proposal which was submitted in the name of the Associated Students of Chemawa Indian

school, and funded in the summer of 1971. The Chemawa Indian Advisory Board was added as a joint grantee, and Mr. Steve Le Buff, project director, and three Indian Alcohol Counselors and a secretary comprise the staff.

Because of its unusual nature, and its apparent effectiveness the research proposal is included here.

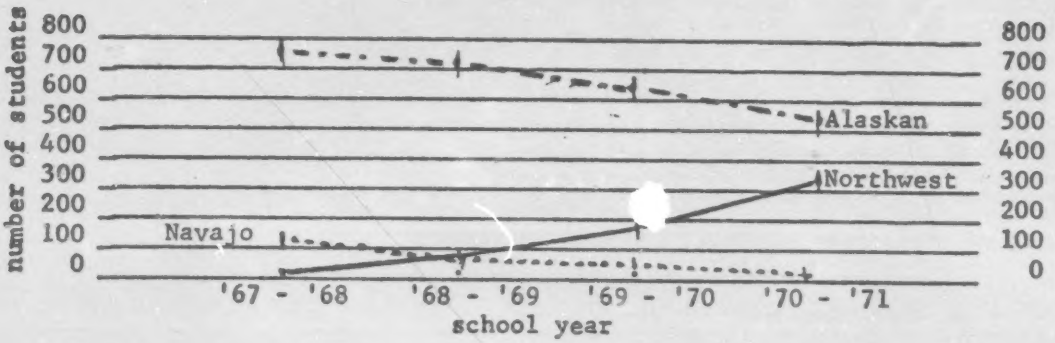
DESCRIPTION OF PROJECT PROPOSAL

A. The Setting:

Chemawa Indian Boarding School is the only Bureau of Indian Affairs boarding school located in the Pacific Northwest. The school campus is located near Salem, Oregon on the site of the original school which began in 1880. At the present time the boarding school has an enrollment of approximately 860 Indian students. The Indian school is in a transition phase, moving towards an acceptance of a larger percentage of students from the Pacific Northwest. Since the 1967-1968 school year the student body has changed from 87 percent Alaskan and 13 percent Navajo to its present composition of 64 percent Alaskan Native and Alaskan Indian, 35 percent Northwest Indian, and 1 percent Navajo Indian students.

CHART I

Chemawa Indian School
Student Referral Changes



This diverse population does not represent all Alaskan, Navajo, or Northwest students who attend Bureau of Indian Affairs boarding schools since many students may be assigned to a school in another geographic area. The students range in age from 14 to 20 and attend grades nine through twelve. Alaskan and Navajo boarding school student referrals most frequently are made on the basis of geographic isolation and lack of public school facilities in their local community. All Northwest reservation communities are situated close to public school facilities which serve the majority of Northwest Indian children. Referral of a Northwest Indian student to boarding school is frequently made on the basis of disorganizing social and inter-personal factors.

B. Extent of the Alcohol Problem:

The student group and school staff have experienced increased stress in the past two years as a result of the change in student population. The stresses have been manifested by a 500 percent increase in the student disciplinary dismissal and dropout rate from the Indian boarding school between the '67 - '68 and '69 - '70 school year. For the disciplinary

dismissals a common picture has emerged. The episode leading to the expulsion is frequently associated with alcohol abuse and disruptive behavior. This is often followed by arrest and a subsequent dismissal. Many students return home only to become permanent dropouts with little hope of continuing their academic careers.

CHART II

Student Dismissal and Dropout Rates

School Year	'67 - '68	'68 - '69	'69 - '70	'70 - '71*
Number of students	26	37	138	112
Percentage of total students	3%	4%	16%	14%

* '70 - '71 statistics represent the first half of the school year only, September - December 1970.

The disciplinary dismissal and voluntary dropout rate for the total student enrollment has increased steadily over the past four years. From the school year '67 - '68 until the '69 - '70 year the combined dismissal and dropout rate rose from 3 percent to 16 percent. There is a 14 percent dismissal-dropout rate for the first half of the school year '70 - '71. It is notable that 74 percent of the disciplinary dismissals in the school year '69 - '70 were Northwest Indian students and that 58 percent of the volunteer dropouts came from the Northwest area. This is statistically significant when one compares the dropout rates with the student body percentages: 64 percent Alaskan, 35 percent Northwest Indian students. In the first half of the 1970-71 school year 78 percent of the disciplinary dismissals and 55 percent of voluntary dropouts came from Northwest students.

CHART III

Percentage of Dismissals and Dropouts by Student Group

School Year	'69-'70 Dismissals (n = 75)	'69-'70 Dropouts (n = 53)	'70-'71* Dismissals (n = 37)	'70-'71* Dropouts (n = 75)
Northwest Students	73%	58%	87%	55%
Alaskan Students	27%	42%	13%	45%

* '70 - '71 statistics represent the first half of the school year only, September - December 1970.

As reported above, there was more than a five fold increase in disciplinary dismissals from school year '68 - '69 to school year '69 - '70. Of 75 dismissals in school year '69 - '70, 36 (48 percent) were related to drinking. Of the 39 disciplinary dismissals in the first half of the school year '70 - '71, 30 (77 percent) were related to drinking. In school year '69 - '70 36 dismissals were caused by alcohol abuse; 19 students were dismissed for repeated drinking; 13 for drinking while AWOL; and 4 for drinking and sniffing various inhalants. The remainder of the dismissals (39) for '69 - '70 were for a variety of reasons; 15 for repeated absenteeism, 4 for fights, 5 related to glue sniffing, and 6 for sexual promiscuity.

CHART IV

Student Dismissals and Dropouts by Category

School year	'67 - '68	'68 - '69	'69 - '70	'70 - '71*
Dismissals:				
drinking	11	9	36	30
other disciplinary (AWOL, rule breaking, fighting, drugs)	3	8	39	9
TOTALS	14	17	75	39
Dropouts:				
student or parent request	4	14	39	*
homesickness	2	1	3	
emotional problems	2	4	5	
transfers	1	0	6	
other	3	1	0	
TOTALS	12	20	53	73

* '70 - '71 statistics represent the first half of the school year only, September - December 1970.

The breakdown of disciplinary dismissals and dropouts by student group is given in Chart V below. If the rates for the first half of the school year September to December of 1970 are projected one sees a continued increase in number of disciplinary dismissals and dropouts. The number of Northwest students given disciplinary dismissals remains significantly higher. One is also impressed with the fact that the dropout rate for both Northwest and Alaskan students rises sharply. It seems likely that the stresses created by a changing student body and the resulting crises of dismissals and dropouts has influenced other students to leave voluntarily as well as some students leaving when their peers were dismissed.

CHART V

Dismissals and Dropouts
by Student Group

School year	'69-'70 Dismissals	'69-'70 Dropouts	'70-'71*Dismissals	'70-'71*Dropouts
Northwest	55	31	32	41
Alaskan	16	22	5	34
Navajo	4	0	0	0
TOTALS	75	53	37	75

* '70 - '71 statistics represent the first half of the school year only, September - December 1970.

There was a total of 859 Indian students at Chemawa in the school year '69 - '70. During that year there were 226 documented occurrences of drinking as compared to 74 in the previous school year.

CHART VI

Occurrences of Documented
Drinking Among Students

School Year	'68 - '69	'69 - '70
Number of Occurrences	74	226

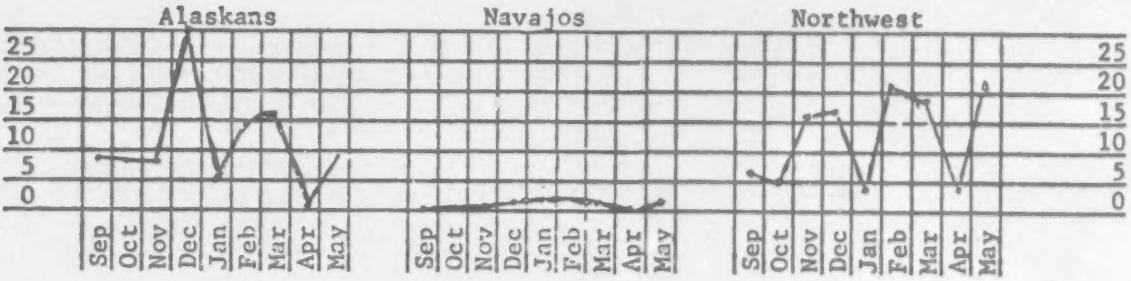
Student Group:

Northwest	115
Alaskan	98
Navajo	13

By analysing the timing of the drinking occurrences it is found that the increases among the Northwest student group preceeded the times when they were allowed to return home (Thanksgiving vacation in November, Christmas vacation in December, Washington's birthday in February, and just before the conclusion of school in May). A dramatic increase in drinking occurred in December with Alaskan students. It is felt that this increase may be related to the fact that Northwest students were allowed to return home while most Alaskans remained at school. This highlights the possibility that while the entire school is in a transition period, there are specific crisis periods at certain times of the year when students feel greater stress which is manifested in alcohol abuse.

CHART VII

Incidents of Documented Drinking at Chemawa
1969-70



It has been stated that alcohol abuse often leads to arrest, subsequent school dismissal and a permanent dropout pattern. In the first half of the school year '70 - '71 (September - December 1970) forty students were arrested a total of 41 times by off campus law enforcement agents. The group consisted of 14 girls and 26 boys. Twenty-four of the total group were under 18 years of age. Nineteen arrests were at school request because of uncontrollable behavior, 18 arrests were off campus, and 4 arrests were by a missing persons bulletin. Of the 41 arrests, 19 were for drunk and disorderly conduct and an additional 14 for possession of alcohol, making 33 of the 41 arrests (80 percent) associated with alcohol abuse.

CHART VIII

Students in Legal Custody
September - December 1970

Reason for arrest:

drunk and disorderly	19
possession of alcohol	14
AWOL and curfew violation	5
shoplifting	2
theft of money	1
TOTALS	41

Special mention should be made of the suicide attempts among the boarding students which are reported for the school year '69 - '70 since the pattern of self-destructive behavior also identifies Northwest students as the population at risk. There was direct association with alcohol abuse and suicide attempt in three episodes. Also, a higher number of suicide attempts took place during the same crisis periods which are associated with alcohol abuse. In the school year '69 - '70 there were 30 attempts by 24 students. There were no successful suicides. The average age for the students who attempted suicide was 18 years. There were 2 males and 22 females in the suicide attempt group. Three girls had multiple attempts which accounted for the additional reported incidences. All students were single. They were enrolled in the ninth through the twelfth grade which includes all levels of this boarding school. Twelve of the 24 students came from Northwest Indian communities, 10 from Alaska and 2 from Navajo. Again, the over representation of the Northwest students in the suicide attempt group is statistically significant.

All thirty suicide attempts took place in the dormitory setting. Thirteen attempts were attributed to a quarrel with a friend or relative while five were thought to be an effort to change a relationship or to express anger. The most common methods of suicide attempts were wrist cutting (seven cases) and drug overdose (20 cases). Thirteen of the 20 drug overdoses were judged to be of minor significance. In 23 attempts the act was discovered by direct communication from the patient. There was a past history of suicide attempts with four people. A psychiatric diagnoses indicating serious mental illness was made with only two patients.

All available information points to the conclusion that referral to Indian boarding school from Northwest Indian reservations selects the students under the greatest social and inter-personal stress, therefore identifying the adolescents who have a higher risk for alcohol abuse and self-destructive behavior. These findings would explain the higher incidence of suicide attempts and alcohol abuse among the Northwest boarding school student population. Although Northwest students as a total group may not experience greater adjustment problems than other groups of Indian students, the Northwest student group selected for boarding school referral come from the highest risk group.

C. THE NEED:

There is no on-going or previous experience with an alcohol abuse program at the Chemawa Indian Boarding School. The present project will integrate its activities with services of the Chemawa Counseling Department of the Bureau of Indian Affairs and the Indian Health Service at the Chemawa Health Center.

D. COMMUNITY PLANNING ACTIVITIES:

This project proposal has evolved from a suggestion for an alcohol abuse prevention program model made to the Associated Students of Chemawa by the mental health consultants of the Indian Health Service. Planning for the project proposal, its administrative structure, and daily operation was done by the Associated Students of Chemawa, the Chemawa Indian School Advisory Board, in consultation with the professional staff from the Boarding School and the Indian Health Service. The Associated Student Group is the elected student council of the Chemawa Indian School, representing all classes and age groups. The president of the Associated Students of Chemawa is elected by the student council. The Chemawa Indian School Advisory Board, composed of six adult representatives of Indian communities from the Pacific Northwest and Alaska, will serve as grantee for this project. A professional advisory group, consisting of members of the Bureau of Indian Affairs boarding school staff and the Indian Health Service, have worked with the student council and the Indian school board to coordinate planning with Bureau of Indian Affairs academic, counseling and dormitory staffs, Indian Health Mental Health consultants and Health Center personnel. All above groups have been involved in planning the project and are committed to support the alcohol abuse prevention project with maximum student involvement.

Planning Meeting of the Student Council on the
Chemawa Alcohol Abuse Prevention Program
February 19, 1971

The following stipulations are included in the Alcohol Abuse Prevention Program at the request of the Student Council. This resolution is used as the program operation outline.

I. Selection of Program Participants

A. Hiring policy for full-time staff:

1. Preference be given to boarding school graduates.

2. A student group will interview job applicants and will make final selection. (Selection to be shared with the Chemawa Indian Advisory Board)

3. A student group will make periodic evaluation of staff performance and efficacy and will retain power of dismissal for unacceptable performance. (Power of dismissal to be shared with the Chemawa Indian Advisory Board)

B. Student Volunteers

1. Dormitory Council (students and staff) will submit names of interested candidates to the Student Council.

2. The Student Council will interview the candidates and make final appointments.

3. Student appointed volunteers will receive academic credit and a stipend for their participation in the program.

II. Mechanics of Program Action

A. Student volunteers will be on call evenings and will be notified as soon as possible and involved in all disruptive behavior related to alcohol and drugs.

B. Decisions to admit, to hold and to release from the holding facility will be made by program members.

C. Transportation from the trouble spot to the holding facility will be the responsibility of the student volunteers and program counselors.

D. Volunteer admissions to the facility will not always be reported for disciplinary action.

E. Guidance Department and program members will consult and work together on input for the students' permanent records and letters home concerning drug and alcohol problems.

E. PROPOSED PROGRAM:

The project staff, consisting of a mental health professional from the fields of counseling, social work, psychology, or psychiatry and two non-professional Indian alcohol caseworkers, will be selected by a joint decision of the student council and the Indian Boarding School Advisory Board. The project staff will receive orientation and training on the techniques of Indian alcohol casework from the Western Regional Indian Alcoholism Training Center in Salt Lake City. The project staff will answer directly to the student council and Indian Advisory Board as their immediate superviers. They will work in the recruitment and training program for the volunteer student assistants and the operation of the holding facility. Student volunteer assistants will be selected by the student council after a nomination from the dormitory councils. Student volunteer assistants will be trained by the project staff and participate with them in a school-wide education program on the effects of alcohol abuse, the management of drinking problems in the dormitory setting, and the staffing of the holding facility. Student volunteer assistants will receive academic credit in a formal health course on alcohol abuse and a stipend for on-call participation in the management of drinking problems which occur after school hours.

The student volunteer group will participate with the project staff in educational discussion groups concerning alcohol abuse, both in the classroom and dormitory setting. This educational program, concerning alcohol abuse, will be directed at the entire student body and will include effects of alcohol on physical and mental health, normal and abnormal patterns of drinking, patterns of alcohol abuse at the Chemawa Boarding School, and operation of the alcohol abuse prevention program. In addition to the group student education program, the volunteer student assistants will participate in an on-call schedule during evening hours and will be notified as soon as possible for involvement in all disruptive behavior related to alcohol and drugs. A decision for admission and discharge of a student to the holding facility will be made by program members following guidelines laid down by the volunteer student assistants and the student council. The holding facility, a group meeting room, and offices for the program staff will be located at the Chemawa Health Center in a wing of the building that allows privacy for an independent program operation and immediate access to medical services. Transportation from the trouble spot to the holding facility will be the responsibility of the student volunteers and program counselors.

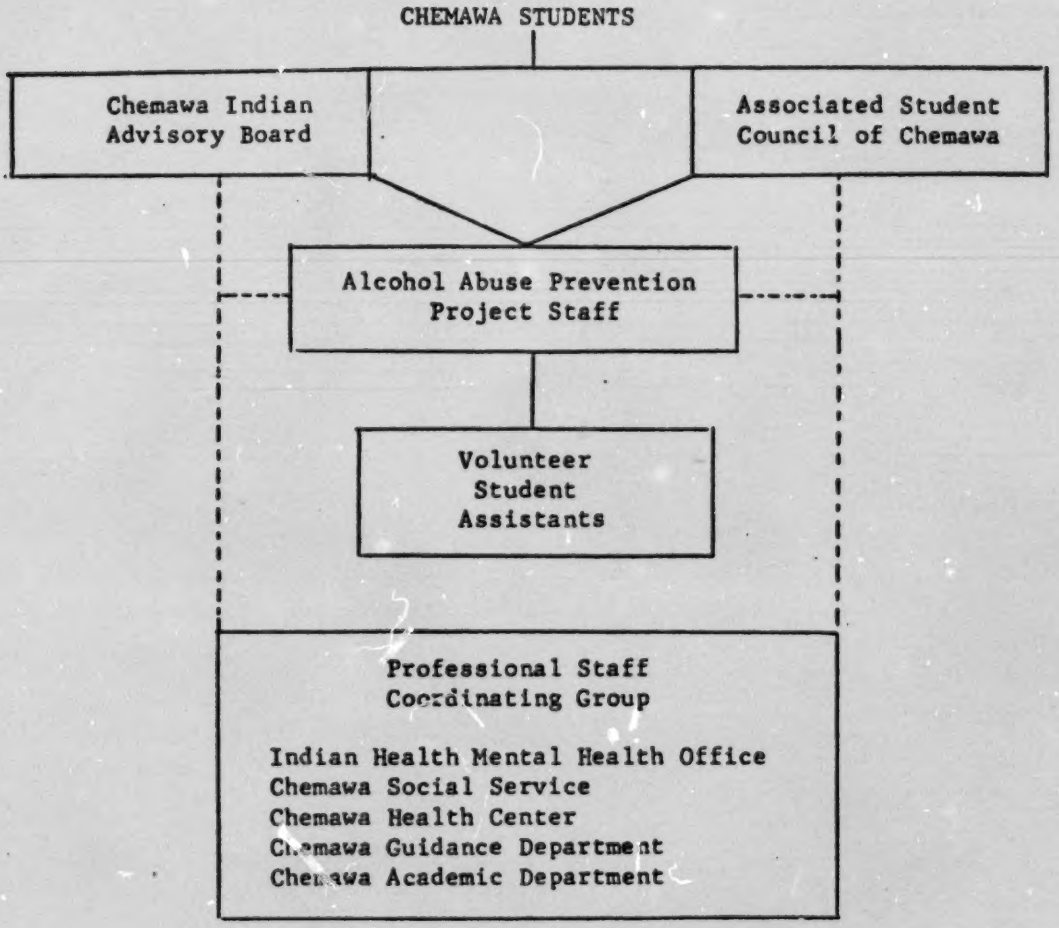
An interdisciplinary group consisting of project staff, volunteer student assistants, boarding school guidance and social service professionals, Indian Health Center staff, and mental health consultants will work together to provide coordinated follow-up for students involved in disruptive behavior. A wide-range of follow-up resources will be developed to include: group educational sessions, group counseling meetings, individual counseling, and peer group discussions.

A professional staff coordinating group has been approved by the student council to assume the responsibility for coordinating activities for the alcohol abuse prevention program with the service departments of the Bureau of Indian Affairs and the Indian Health Service:

Name	Title	Coordinator to:
James H. Shore, M.D.	Chief, Mental Health Office Indian Health Service Portland Area	Indian Health Service Mental Health Office and Project Staff
Patricia E. Ernstrom,MSW	Director of Social Services Chemawa Boarding School	Indian Advisory Board
Thomas C. Seidl Pharmacist	Service Unit Director Chemawa Health Center Indian Health Service	Chemawa Indian Health Service Center
Joseph F. Coburn, MSW	Boarding School Guidance Counselor	Associated Students of Chemawa
N.B. Jetmalani, M.D.	Psychiatric Consultant Chemawa Boarding School	Project Staff
Clement A. Azure	Academic Supervisor	Academic Department
Leo B. Henry	Social Services Counselor	Bureau of Indian Affairs Guidance Department.

ORGANIZATIONAL CHART
for

CHEMAWA INDIAN SCHOOL
ALCOHOL ABUSE PREVENTION PROJECT



G. STAFF RECRUITMENT:

The position of the project director will be filled by a mental health professional with preference for an Indian person. The mental health professional's background can include a degree in the fields of psychiatric social work, psychology, guidance, or mental health consultation. The alcohol caseworkers must be Indian people recruited from the Pacific Northwest with preference given to boarding school graduates. Recovered alcoholics who can show capability for working with the student group will also be given preference in consideration.

H. PREVENTION AND TREATMENT:

In developing an alcohol abuse education program within the boarding school setting and a holding facility as an alternative to arrest and jail, the program staff will attempt to change attitudes and behavior patterns about alcohol use. Most students at boarding school would not be judged to be alcoholic. And yet, the effects of alcohol abuse cause major impairment in their life adjustment if it results in disruptive behavior, arrest, dismissal or dropout. Primary prevention of this vicious cycle would appear to do much towards changing the disruptive chronic effects of alcohol abuse for these Indian young people. Program results can be evaluated by the impact on the dismissal and dropout rates and the number of reported occurrences of alcohol abuse. Furthermore, individual admissions to the holding facility will be documented by a confidential medical record form which will allow a follow-up assessment of the effect on the individual careers of Indian students.

I. SERVICES IN KIND:

In-kind service contributions to the operation of the alcohol abuse prevention program include:

Bureau of Indian Affairs, Guidance Department
Bureau of Indian Affairs, Social Services
Indian Health Service, Health Staff
Indian Health Service, Health Center space for the holding facility, group meeting room, and staff offices
Indian Health Service, mental health consultation

No other Federal grants are involved in the funding of this project.

Reading between the lines of the proposal, with the known history of the Portland are Mental Health programs, will show that the Portland Area staff and the IHS contract psychiatrist played a consultative and collaborative role in developing this program. The Chemawa School Alcohol Abuse Preventive program illustrates the model set forth as an ideal for the Area of having a local group develop specific services according to a definition of their own needs. The reduction in the number of disciplinary actions, arrests, and school dropouts associated with alcohol abuse has been stated in generally favorable terms. It is to be hoped that the research expertise of the Mental Health staff will help evaluate the program over time.

2. Warm Springs Mental Health and Alcohol Project

This program was initiated in 1972, with a tribal contract. Planning this project was carried on throughout 1970-72. A fuller description has been added as a special section of this report. In order to note it in its proper historical sequence the brief summary included in the 1972 report is quoted below:

Warm Springs Tribal Mental Health-Alcohol Project

Indian Health contract alcohol funds for the Pacific Northwest were awarded to the Warm Springs tribe, which is placing all mental health and alcohol related programs under a single tribal department. The tribal council, in showing their participation in the development of a tribal alcohol and mental health program has contributed $10,000 annually to hire a mental health worker. This is one of the first Indian mental health workers in the country hired with tribal funds. The position will work closely with the coordinated mental health and alcohol department. Mr. William Nicholls, formerly with WRIATC*, is the director of this program. Additional program staff (two Indian alcohol counselors and a secretary) have been hired, are participating in an in-service training program, and are actively involved in field casework and development of rehabilitation resources.

*Western Region Indian Alcohol Training Center, Salt Lake City

3. Fort Hall Suicide Prevention Program: Progress in 1970-72

This work continued as summarized below from a progress report submitted to NIMH.

Fort Hall Suicide Prevention Center

The NIMH funded a three year suicide research grant to the Shoshone-Bannock Tribe starting June 1, 1971 for a total of $31,240.00 for the first year. The purpose of the grant was to follow-up a pilot study of "Adolescent Suicide at the Fort Hall Indian Reservation" and to evaluate the effectiveness of a community treatment center created on the reservation to deal with self-destructive crises. Dr. James Shore (of IHS) and Dr. Jerrold Leby, Professor of Anthropology, University of Arizona, are co-principal investigatores. Mr. Don Gordon is the field research assistant.

Research goals included:

1. Evaluation of the reservation-based and tribally-sponsored medical holding center designed for crisis intervention and suicide prevention in an Indian community.

2. Review of records to evaluate the behavioral adjustment of individuals treated in the medical holding center.

3. Establishment of long-term rates of suicide, suicide attempts, and crimes of violence for this tribal group.

4. Utilization of field interview methodology to verify the population at risk and to determine if the population served by the medical holding center is identical to the population at risk.

5. A long term follow-up at two and five years to evaluate the effect of the medical holding center on behavioral adjustment of treated individuals. A follow-up to evaluate the effects of the center on multiple social pathologies as reflected by community rates of arrests, accidents, drug abuse, school dropouts, and the incidence of broken marriages. And documentation of community participation in the development and operation of the medical holding center.

Although completed suicides have not been reduced by the work of the program to date, it is clear that a better understanding of the program's operation will help us direct outreach workers to an earlier stage of intervention in providing a more meaningful service to this Indian community.

Data from different aspects of the research projects are being collected. An analysis of data is in progress. Preliminary analysis indicates that predictive factors can be isolated to identify high risk families.

Unfortunately this project was abruptly terminated for a number of complex reasons. The official record notes this fact critically:

"Due to administrative problems this grant will be terminated after one year of implementation."

C. Area Wide Involvement in Mental Health Records & Case Reporting

As part of a concern in all IHS Areas, studies were made of IHS Mental Health Records. Dr. James Shore became chairman of a national committee to develop adequate record forms and to develop special registers for suicide prevention, alcoholism and other prominent mental health problems. The brief report in the Area report of 1972 describes this activity succinctly.

Mental Health Information System

Dr. Shore is chariman of two committees on data and evaluation. The primary emphasis of these committees has been the development of a patient-centered, problem-oriented, inter-disciplinary reporting system with guidelines for standards of care. See sample of Portland Area reporting form. A problem list avoids diagnostic labels and enables an interdisciplinary team to use a common reporting system regardless of the level of training and experience.

The present patient counseling report from will be used in all Portland Area service units during the months of July, August, and September. Based on the results of the pilot project and others a national reporting system will be established for the Social Services and Mental Health Programs of the Indian Health Service.

The establishment of high risk case registers are being started in each service unit of the Portland Area. At this time a minimal standard of care has been developed for the Suicide Register.

Standards of care for the other categories will be developed. These include:

1. suicidal behavior
2. childhood hyperactivity
3. schizophrenia
4. alcohol abuse
5. mental retardation

Program planning and evaluation of each service unit mental health program will begin to incorporated the epidemiological pattern and projected treatment plan for each high risk category.

The IHS Mental Health programs are not free standing. The record systems they develop must be integrated with that of the total health care program, and often other personnel besides mental health staff have relevant information to share and a separate set of patient and activity records to keep. This was recognized by the Portland Area and an effort made to co-ordinate their own work with that of other staff is noted in the 1972 Area report.

Mental Health Record Standardization Project

Miss VonFumetti has been requested by Dr. Shore to develop a format for standardization of mental health records. While the project has just been formulated, several possibilities have been discussed.

1. Any standardization format should be developed jointly with social services, medical records, and mental health.

2. The possibility of using the public health nurses family folder as a basis for a social history.
Utilization of a standardized family history rather than an individual history.

3. If separate records are maintained the central linkage should be the medical chart.

It is anticipated that this project will require lengthy negotiations with all concerned programs.

V. PROGRAM DEVELOPMENTS 1973-74

A. Staffing Patterns

1. Personnel Changes

In the Area Office, two major departures took place during this period. Dr. James Shore left IHS in the Summer of 1973 to assume responsibility for the development of a community psychiatry program with the University of Oregon Medical School in Portland. He continues his deep involvement in American Indian Mental Health, and continues as a consultant to the IHS both at the national and Area level. His variety of research interests in a number of projects will continue, and as the new department within the Medical School program evolves it will

undoubtedly become a base for more Resident and Medical student participation in IHS programs as they evolve.

Ms. Von Fumetti, who had earlier received commendations for her administrative work as Deputy Chief, was promoted to Chief of the programs and continues her previous activities. However, with the additional administrative duties she has relinquished some of her consultations to the Northern Puget Sound Reservations. Mr. John Bopp is taking a more active role with STOWW, and Mr. Al Tolz, Chief of Portland Area Social Services, began functioning in 1973-74 as a M.H. Consultant to some Northwestern Service Units.

Dr. Rosalie Howard also left IHS, in the Spring of 1973, to enter private consulting practice in Eugene, Oregon, Her interest in some of the training activities still continues, and she may become available as a consultant on contract bases to programs such as those at Chemawa which are within easy travelling distance of her new home.

Dolores Gregory, M.D., joined the Area staff in the Fall of 1973 to provide a psychiatric member and to consult with Yakima, Warm Springs, Colville, and the emerging program on the Spokane reservation.

Carolyn Dearborn, who was the first secretary to the Area Office Mental Health team has been promoted to Administrative Assistant.

At the Service Unit level a number of changes are also evident. A master's level social worker, Mr. Pepper, has replaced Thelma Waller at Fort Hall. At Bellingham, a clinical psychologist is available for therapy sessions under contract, and Jay Navarro, M.A. has been added to the Lummi Service unit as a full-time staff member. He will also consult with Swinomish and Nooksak located nearby. Lummi Service unit has general responsibiiities for these Northern Puget Sound reservations. This will free Mr. John Bopp, MSW to concentrate on the Lower Puget Sound group organized under STOWW.

Nancy Melise, MSW, has been added to the Colville staff, and together with Josephine Marcelly has provided services to the adjacent Spokane Reservation for nearly a year. Chris Sijohn has been recruited at the Spokane Reservation, which will now have its own mental health worker. The Colville staff will continue to accompany the Area Psychiatrist on regular consultation visits to the Spokane Reservation until that program has taken root.

Paula Hope has replaced Donna Grosz at Neah Bay as a Mental Health worker. Clarence Cowapoo has been added to the staff at Umatilla, where Mr. Terry Farrow has been given leave for long term training. Peter Olney has been added to the staff at Yakima.

2. Paraprofessional Supervision

The professional IHS Mental Health staff make their training and supervisory expertise widely available upon request.

In general there are estimates that each of the professional persons closely supervises the work of at least four paraprofessionals, although a count of the total number of IHS Mental Health Workers on all the reservations does not appear to equal this total. However, such a count must include Tribal Alcoholism counselors, Johnson O'Malley school counselors, Child Care Workers in Head Start and Day Care or group home projects, as well as VISTA and IHS Mental Health workers and Social Work Associates. The total runs well over 100 mental health paraprofessionals working in the Area. Supervision and training of these many workers would not be possible without the close cooperation of IHS Social Services with professionals from other agencies' personnel at the Service Unit and Area level. A special Report on Training was prepared by Dr. Rosalie Howard and is available from the Portland Area Office: Howard, R., Shore, J., VonFumetti, B.: Mental Health Worker Training. M.H. Office Report, No.4 pp. 1-59, July 1973.

3. National Social Work Associate Program

As of 1973-74 there are no Social Work Associates in the Portland Area Mental Health Program. However, the overall IHS program for this training is headquartered at Yakima, under the direction of Maxine Robbins, MSW, who is a member of the Yakima Tribe. Ms. Robbins has developed an entry level position, where local Indian members can be supervised by Social Workers and also participate in available Area and Academic training. This position provided the initial entry for many Service Units outside the Portland Area who saw the need for a papaprofessional development before their Mental Health programs developed sufficiently to establish separate positions. In some Areas supervision is performed now by Mental Health programs staff, and in others social work associates have moved along the career lattice to mental health specialist positions at a higher grade after completing their training and gaining experience. Some social work associates remain with the Social Services branch, and theoretically at least may in time be able to develop sufficient skill and training to qualify for BA and SW's positions. Although fewer in number than mental health workers, the social work associates make a distinguished contribution, partly perhaps because of careful selection critaria, and partly because of the intensive highly individualized on-the-job training which they receive.

In addition to her national IHS responsibilities, Ms.Robbins takes an active interest in Yakima programs and is a resource person for the Area.

4. Centralization versus Decentralization

As can be seen from the pattern described above, the Area Mental Health staff still continues as a centralized operation, with senior consultants travelling to each of the Service Units. However, as programs have developed professional personnel of at least the Master's degree level

have been established in most service units, and under their direction programs have been functioning quite autonomously. Consultant contracts with local psychiatrists and other clinical specialists continue. Liaison with such resources as the Eastern Oregon Comprehensive Mental Health Center which serves Umatilla and Warm Springs, and the CMHC in Southern Idaho at Pocatello, near Fort Hall, supplement the work of the Area Office staff.

In many ways the development of the Mental Health programs in the Portland Area are decentralized and autonomous, but are tied together by the Area Office staff who meet together and share the experiences and planning that has occurred on their consultant visits. It would appear that the programs in this Area are in a developmental phase where travelling from Portland imposes considerable strain on the senior professional staff at the Area office, but where other modes of operation on a decentralized basis have just begun to emerge.

B. Staff Activity

1. Development of the Mental Health & Social Services Report Forms

The Portland Area has done a number of pilot studies over its first five years in the development of a more useful way of recording case data both for records at the various Service Unit programs and also as part of a national IHS effort to develop an appropriate record system. Starting with the logs kept by each member of the Mental Health Team as the Area program began, a number of lists of commonly seen problems, of ways to interlock with Ambulatory Care Records kept in the Service Units, and ways to include staff and client identifying information without jeopardizing privacy have been tested. The work done in this Area has been coodinated with that of

committees in other Areas. In the summer of 1973 a national automated data processed report form, utilizing approximately 65 problem descriptions plus other pertinent information was put into use by the MH and SS staffs in all IHS Areas. Dr. Shore continues as a consultant to the IHS Data Committee charged with overview of this activity.

This project has been integrated with similar efforts and concerns of the Social Services Branch of IHS, and the form designed to meet the needs of both programs. The results of this program have been the beginnings of standardized reporting which can be utilized for record keeping and data analysis. They also suggest considerable clarification of the actual tasks confronting mental health staff and their use of resources and deployment of personnel. A further analysis of these data as they become available, can make the similarities and differences in individual programs identifiable, as well as provide indications of the scope and nature of utilization of IHS services in the Mental Health and Social Services.

2. Analysis of 1971 Staff Activity

As part of the development of data report forms for all Areas, an analysis of direct patient services in the Portland Area for the six month period January to June 30, 1971 was prepared. The monthly average for staff members, based on reports from two Area Office Consultants, one field based MSW and 5 Mental Health workers was 49, with a range

from 25 to 105 per month. Including both patient-oriented and program-oriented contacts, the total for the six month period was 2,352 contacts.

A micro analysis of the actual contacts for the Area Office Psychiatrist, a Mental Health worker and one of the MSW field staff was reported to demonstrate possible bias in types of activity between these three roles in the operation of Mental Health programs. This table is reproduced following for comparison with later material collected in 1973.

Of equal interest is the table reporting of the number of patients seen by diagnostic category, summing all reports by all Mental Health staff. Those categories of patients which deviated from expected proportions according to epidemiological reports of other populations are indicated with an asterisk. (See second table following.)

A certain skewness in patients seen seems to be partially related to the sex of the staff member. Male staff apparently see equal numbers of men and women, while women staff members seem to see about 2.5 women for each man. This finding is of particular interest in relation to the general impression, born out by the careful epidemiologic studies at Neah Bay in 1967-68, that women are more frequently users of IHS medical facilities than men, even though the majority of IHS physicians are male. No hypotheses were advanced by the Portland Area staff to account for these findings.

A COMPARISON OF ROLES
(Consultant's Bias)

	Area Consultant	Mental Health Worker	Field-MSW
Consultees			
patient	93	105	107
(missed appt)	(17)	(0)	(11)
MHW	23	2	125
	(17)	(1)	(0)
CHR	16	12	5
MD	35	20	8
health staff	56	1	41
(case consultation)	(73)	(91)	(105)
school	6	15	19
tribal government	12	3	3
com. group	8	1	28
alcohol caseworker	12	13	2
state agency	11	23	52
BIA	10	9	11
other	20	46	68
phone	34	5	47
individual	82	145	190
group	42	7	77

PATIENTS BY DIAGNOSIS

	Male	Female	Total
organic brain syndrome	3	1	4
functional psychosis	2	20	22*
neurosis	5	48	53
personality disorder	24	41	65*
psychophysiological reaction	0	19	19*
transient situational disturbance	21	120	141
beh. disorder, childhood or adolesc.	62	105	167*
social maladjustment	25	70	95
drug dependence of abuse	1	13	14*
alcohol intoxication	42	68	110
chronic alcoholism, DT's, or alcohol psychosis	100	59	159
mental retardation	2	2	4*

* (an obvious deviation from the expected epidemiology pattern)

3. 1973 Estimates of Staff Activities

Since the problem oriented Mental Health and Social Service Reporting system was just being introduced in the summer of 1973, its resulting data were not available for analysis in this report. Instead, an attempt to secure self descriptions of staff activities was made, utilizing a standard interview or written format. This was distributed by mail during the summer of 1973 to all staff not available for interview. 6 out of 7 professional staff completed the report, and 5 of the 8 IHS Mental Health workers.

A compilation of the results shows that the activity emphasis of the IHS Mental Health staff is very much patient oriented. The professional staff estimate that on the average 63% of their time is so spent, 40% in direct clinical services and 23% in consultations about patients. The Mental Health workers on the average spend 50% of their time in patient oriented services; 30% in direct clinical services and 20% in consultations about patients.

The professionals report an average of 15% of their time in program consultation, and the remaining 17% in administration. MHW's spend on the average about 16% of their time consulting about mental health programs.

The Mental Health workers and 4 of the six professionals report that 10% of their time is spent in learning activities for self development and career skills, and the remaining 20-26% of their time is spent in administrative paperwork. Only one professional, and no Mental Health workers report that they are engaged in formal teaching and training activities.

PORTLAND AREA - SUMMER 1973

REPORTED CONSULTATION BETWEEN MENTAL HEALTH STAFF AND OTHER AGENCIES

Agency	By Professionals (N=6) About patients	About programs	Scheduled appointments or contracts	By Mental Health Workers (N=5) About patients	About programs	Scheduled appointments or contracts
IHS Physicians	6	4	3	5	5	---
IHS Clinic Nurses	6	4	2	4	1	---
IHS P.H.N.	5	3	2	5	2	---
Other IHS staff	5	5	2	5	2	---
Comm. Health Rep.	5	5	3	5	2	---
Pvt. M.D./Clinics	3	1	---	2	2	---
County Health Dept	--	--	--	1	1	---
Community MHC	5	5	1	5	2	---
State Hospitals	5	3	--	4	2	---
Traditional Healers	4	1	1	2	1	---
Public Schools	6	3	1	3	2	---
Johnson O'Malley Counselors	1	1	1	---	---	---
BIA Schools	2	2	2	1	1	---
Parochial Schools	1	1	--	1	1	---
Head Start	6	2	3	1	1	---
Day Care	3	1	1	--	1	---
State & Co. Welfare	5	5	---	4	2	---
BIA Social Service	--	1	--	1	---	---
Vocational Rehab.	3	2	---	2	1	---
Alcoholism Program	6	6	3	2	2	---
Detox. Staff	2	--	--	1	1	---
Halfway House	2	2	---	1	1	---
Tribal Courts	5	4	1	3	2	---
State/Local Courts	5	3	---	2	2	---
Tribal Police	5	5	2	2	2	---
Local Police, Sheriff	3	4	1	2	2	---
Jails	3	4	1	2	2	---
Prison Officials	1	1	---	---	---	---
LEAA	1	1	1	---	---	---
Tribal Leaders	1	1	---	---	---	---
C.A.P.	1	1	---	---	---	---
Totals	106	81	31	66	43	0

NOTE: This table should be read as follows: 6 out of 6 professional staff members reported consultations with IHS physicians about patients; 4 out of 6 reported consultations with IHS physicians about programs; 3 out of 6 had regularly scheduled appointments or contracts for these consultations; 5 out of 5 mental health workers indicated that they consult about patients with IHS physicians; 5 out of 5 consult with IHS physicians about programs; none have regularly scheduled appointments or contract arrangements for providing these services.

The distribution of agencies with whom IHS Mental Health staff have consulting relationships is shown in the previous table. The agencies are grouped so that health facilities, educational facilities, welfare, alcoholism and law related agencies are shown together.

4. Suicide Epidemiology Developed

In an article entitled "American Indian Suicide--Fact and Fantasy," to be published in Psychiatry in 1975, Dr. James Shore summarizes the results of the careful records kept in the Area Suicide register and problem oriented data records throughout the Portland Area subsequent to initiating the program at Fort Hall. In this article he presents epidemiological evidence to challenge the general stereotype of all Indians as high suicide risks by demonstrating that when the data are examined, one tribe contributes over 50% of the completed suicides, and a high proportion of the suicide attempts reported. When these figures are parceled out this reservation (Fort Hall) does stand at high risk by anyone's standard, while other tribes in the Area compare favorably with national averages for non-Indian populations, and some have rates that are substantially lower. Tribes not at high risk seem to show an older age person attempting and completing suicide (mean age 32). The high risk tribe accounts for most of the suicide attempts that occurred in jails. Seventy-five percent of the suicide attempts for this tribe are associated with alcohol abuse in contrast with 31% of the attempts in other Northwestern tribes.

Epidemics of suicides attempted and completed are also typical of the high risk tribe. Even in heterogeneous populations, such as those found in BIA Boarding Schools, the contagion of suicide attempts seem to involve extended family members of the initial perpetrator, together

with other tribal members from the high risk tribe. The pattern suggests that not only are there high risk tribes, but that the greatest risk of both homicide and suicide are associated with not more than one fourth of the tribe whose social and family histories render them particularly vulnerable.

This article discusses the problem of eradicating the suicidal stereotype that has been publicized as a label for all American Indian populations. Both Indian and professional audiences seem to reject earlier evidence from studies in the Southwest and move from that over simplified position to discrimination among high risk groups. Dr. Shore also indicates the further danger of intensifying the stress on high risk tribes and sub-populations of tribes by careless use of epidemiological data. The need for such data, and for further epidemiologic studies is evident, and should be an outcome of the national implementation of the automated reporting system of problem oriented case contacts, and of a set of standards of care based upon the nationally established Suicide Register now being kept in all IHS Area Mental Health programs. As highly vulnerable tribes and sub-populations are identified, developing preventive programs must include precautions against giving the suicide prone labels that they will unconsciously be drawn to live up to.

C. Selected Service Unit Programs

1. Northwest Coastal Tribes

a. Lummi, Swinomish and Nooksak (Northwest Washington Service Unit)

The Lummi reservation is located on a peninsula just out into Puget Sound, just west of Bellingham, Washington. Through previous land sales and treaty revisions almost all the beach front land now belongs

to non-Indians, and the tribe has lost title to the large Island that bears their name a short ferry ride off shore.

The program for mental health work at Lummi began first with an Alcoholism counseling program supported by IHS indirectly but funded through CAP and NIAAA. The two-counselor staff received training through the University of Utah, in the Indian Alcoholism training program, and also participated in the traditional religious and healing practices of the tribe. In 1972 one of the team transferred to IHS and became a full time Mental Health worker, being replaced by other staff in the Alcoholism program which continued to function.

Mr. Washington's work as a paraprofessional receives support and clinical services back-up from two professionals: a clinical psychologist in Bellingham who sees individual referrals under contract health care provisions and Mr. John Bopp, MSW, of IHS. Mr. Bopp moved in 1972 from Fort Hall where he had been SUD to the Seattle IHS office established in the USPHS hospital, to facilitate services to the Western Washington Tribes. Mr. Bopp was available for seeing patients and for consultation twice weekly for a half day at Lummi.

In the fall of 1973, Jay Navarro, M.A., was assigned full-time to Lummi, and its satellite health stations at Swinomish and Nooksak. Mr. Bopp is gradually withdrawing his services from the Northwest Washington Service Unit and concentrating his services with STOWW tribes to the South and along the Western shores of Puget Sound.

The Lummi tribe has recently received national recognition for its aquaculture projects, and is developing an industrial base by applying the latest marine biology discoveries to the raising of both fish (Salmon and Trout) and Oysters. It is very much a tribe in transition, with children as young as five and six years of age attending public schools,

requiring long bus rides; and yet retaining its traditional practices similar to those of many of the Northwest Coastal tribes. It uses the most sophisticated techniques for raising and counting micro-organisms in its aquaculture being willing to hire expertise from Japan as well as the U.S., yet is constantly apprenticing tribal members to study and learn enough to take over the total operation. It has a modern boys' club program, and many other tribally organized efforts to develop preventive as well as treatment facilities. The mental health program is one of many where the pressure to acquire sufficient tribal expertise to completely handle their own program is quite high.

Both in light of their earlier cultural history as an aggressive and status conscious tribe, and in light of today's pressures to reclaim their holdings and establish themselves as a viable competitive economic and self sufficient unit, it is not surprising that one of the commonest needs for a physician at the Lummi Health Center has been to patch up the men after strenuous fights. While it was not possible to analyze the records and establish the documentation scientifically, the SUD in 1973 reported his observations of the usefulness of the Mental Health program in an interesting manner. He indicated that while the absolute number of persons requiring medical attention had not been reduced, the severity of the injuries had fallen off markedly to bruises, lesser cuts, and lacerations, instead of broken bones and deep stab wounds. This observation suggests a new set of criteria for measuring success of mental health programs. If the technical problems involved can be solved, this kind of evidence may be more realistic and practical than many which have been asserted or sought in the past.

b. Small Tribes of Western Washington (Western Washington Service Unit)

These small reservations and groups represent many pockets of Indian coastal villages that border on the Puget Sound and its adjacent lowland rivers. Some of them have never been federally recognized, some have still retained BIA services, and some have been terminated at various periods of historical development in the past. Their recent loosely organized political unit attempts to render them more effective in negotiating treaty rights, particularly those involving fishing and land payments. Membership shifts its composition according to the issue being joined. Since IHS was formed to provide services to BIA administered reservations, much of its present structure parallels that of the older federal agency. Thus only a portion of these tribes are eligible for IHS services, even though the individuals and tribal villages may have almost identical needs. The non-eligible group, like those in urban settings, is beginning to question this restrictive interpretation, and some negotiation of contracts and other ways of providing health services arises as an issue from time to time. The urban Indian who has not been away from an IHS served reservation for a year is eligible for health care, including mental health services. This exceeds eligibility for many BIA services, which cease after three months away from the reservation, or sometimes with any official change of residence away from the geographic limits established by the BIA.

IHS has maintained an office for many years in the USPHS Hospital in Seattle, whose primary obligation is to serve the U.S. Coast Guard and Merchant Marine in the Northwest. However, this office has until very recently been utilized for the purpose of establishing eligibility and

for arranging for contract medical services, since Seattle, like Portland, is used by the entire Northwest for health resources. Indian persons from the Billings and Anchorage Areas, as well as from the Portland Area, often travel to Seattle or Portland for specialists and health care not locally available.

Since 1972, however, direct services of a mental health nature have been added. Mr. John Bopp, who has both clinical social work experience, as well as having the administrative experience as SUD at Fort Hall for a period of several years, travels to the reservations around Puget Sound, providing both clinical and consultative serves in the mental health field. In the first year the notable progress made at the Lummi reservation has been already described. In 1973-74 the shift away from Lummi allows for a survey of both needs and potentials of the many smaller units, and the beginnings of designing a program to meet their characteristics. It is too soon yet to project the dimensions of this program, but it should be watched for its potential for inter-tribal development as well as for patterns of clinical service delivery.

c. Makah, Quilleute, and Lower Elwah (Neah Bay Service Unit)

The early work done at Neah Bay has provided a sound epidemiological base. The discovery of the relatively high rate of peptic and especially duodenal ulcers was throughly discussed with the medical staff and has resulted in active programs of prevention and follow-up by that staff. The community itself has undertaken economic development and other programs to relieve some of the stresses of poverty, and has an active interest in solving some of its own stress involving situations. Meanwhile clinical and programmatic consultations have continued to involve one or more staff from the Area Office and residents in the training programs at the

University of Washington Medical School. It is too early for follow-up studies of the detailed nature as the original ones to measure results of the programs in mental health and other IHS and tribal activities.

d. Quinault, Ehehalis, Soalwater and Hoh (Quinault Service Unit)

At Taholoh the Quinault Service Unit and its satellite stations have been receiving regular consultation visits from the Area Office staff and have also an interest in the work of Mental Health technicians. However, no records or accounts of particular programs on these reservations is available for inclusion in this report.

2. Rocky Mountain Tribes

Nez Perce, Coeur d'Alene, and Kootenai

(Northern Idaho Service Unit)

The Idaho Service Unit is headquartered at Lopwai , but coordinates services on several reservations which are just beginning to emerge with an identity as separate mental health programs.

The Nez Perce Reservation has been served by Mr. Robert Francis, B.A., from the Colville Reservation whose former experience has been in family counseling, and by Mr. Tom Keast, MSW, whose prior experience has been on the Crow Reservation when the first psychiatric consultation contracts there were developed. Although no descriptions and observations of his experiences with the Nez Perce have been written, there is every reason to believe that he would have some contributions to make in comparing these two tribes, with very different histories, but also with long associations of cooperative relationships with the white society. The Nez Perce Reservation, situated in a mountain valley near Lewiston, Idaho, has a dramatic history of its attempts to first accommodate with

the white culture under Chief Joseph the Elder, and later, after disillusionment, to withdraw into Canada under his son, the younger Chief Joseph. However, this all took place 100 years ago, and a picture of the contemporary problems as well as a report of the efforts being made to solve them would be very helpful.

The Coeur d'Alene Reservation has also been included under the staff at Lapwai. This reservation lies along the south shores and in the mountains below Lake Coeur d'Alene, due east of Spokane.

At the far northern end of the Idaho panhandle near the Canadian border is the small tribe of Kootenai, who are also served by this Service Unit.

Consultations from the Area Office Team have stimulated an interest in mental health program development, and regular schedules for clinical services seem to be evolving on all three locations. The analysis of data from the standardized reporting forms for Mental Health and Social Service may yield a much clearer picture of the staff activities and tribal needs than is presently available. Part of the problem with centralized professional consultations, when such great distances are involved, is documenting all of the activities and plans as well as seeing the patients and agencies on each trip that is made. As has been noted, the Portland Area Mental Health programs are just now reaching the level of growth and development where staff deployment at the Service Unit level can be emphasized.

3. Great Basin Reservations

Shoshone and Bannock Tribes (Fort Hall Service Unit)

There are actually two reservations that lie mostly within the arid Great Basin and Range country. The Duck Valley Reservation straddles the state line between Idaho and Nevada, and is included with other Nevada reservations in the report from the Phoenix Area. Fort Hall lies along the early rises of the Snake River, whose actual source is traced back into Yellowstone Park along the Nevada-Wyoming border. However, although it has some land that is part of the Columbia Plateau, its terrain most nearly resembles the arid deserts of the Great Basin in its characteristic sagebrush vegetation and high, dry climate. Pocatello, Idaho, to the south is the largest nearby city. The city of Blackfoot, Idaho, to the north is also one to which the population relates in commerce, employment, and law enforcement.

The earlier interest in and development of suicide prevention facilities have been described. The Holding Facility was established, and with the cooperation of the tribal police, well used. The sheriff's office and state police to the north, operating from Blackfoot, Idaho, also cooperated well. There were in the succeeding years no suicides within these jails, and the individuals who received help from the volunteers and mental health staff seemed not to suffer relapses or to be further involved in suicidal behavior for a period of several years of follow-up. However, there seemed to be intense resistance to the mental health approach in Pocatello, and the police of that city did not become involved in the program until some highly publicized deaths forced them to do so. Relationships with this community seem strained and a high degree of prejudice seems to be characteristic of the white communities' attitudes toward Indians in general, and the Shoshone-Bannock tribes at Fort Hall in particular.

Discouraging to the tribe has been the shift in locale from jail to homes, and public entertainment facilities. The actual rate of attempts has not seemed to decrease up through 1972, although the alertness of the population and the increase in understanding of what needed to be done to alleviate the distress has somewhat reduced the number of suicide completions. Current reports indicate a broad program of mental health activities. Arrangements for consultation and services from the Idaho mental health system and particularly the CMHC located in Pocatello took a good deal of negotiation, and at times more satisfactory results were obtained from contracts with clinical personnel in private practice.

It is quite clear from the reports that the utilization of suicidal and self-destructive behavior is both a desperate impulse, and a response to many other needs, and the long range mental health program must become oriented around family counseling, work with community agencies, and with the youth of the community in a full range of services. The previously reported analyses of the epidemiology of suicidal behavior prepared by Dr. Shore will permit this focus to be developed, and that analyses of the more recent staff reports of their activities will reflect these trends when they become available.

4. Columbia Plateau Reservations

a. Yakima Service Unit

The Yakima Reservation is home not only to the Yakima tribe, but also remnants of 13 other tribes who were organized into a confederation in the middle of the last century. It has only recently succeeded in securing the return of Mount Adams, in the Cascades, which was an important part of the tribal religious life of the bulk of the people on the reservation. Most of the land within reservation boundaries lies along

the early rises of the Yakima River, at the edges of the lush fruit growing Yakima Valley. It is difficult to assess the degree of integration of these tribes into the mainstream of the dominant culture, since they are somewhat varied. However, English seems to dominate as a common language, and the chief problems seem an alternation of pride and depression as individuals and sub-groups are able to manage successfully to compete in the outside world. Finding ways for sub-populations to work together may be the main ingredient for resolving the stress of cross-cultural collisions with the white world.

The pattern of community and clinical consultation that was initiated here before the formal establishment of Area Mental Health Programs has continued, and both tribal activities and other agencies assume responsibilities for working with many mental health problems. Two programs seem to involve major elements of the tribe and the Mental Health staff. The first is a school on the reservation for retarded and handicapped children ranging in age from pre-school to elementary school. Evaluation of these children, consultations with the teachers, and assistance in parental and family counseling are IHS Mental Health staff activities, as they are in relation to Headstart programs on the Yakima Reservation. The operation of the school itself is a community and tribal program.

The second program that involves a number of Yakima personnel and clientele is the Sundown M Ranch, a rehabilitation center for alcoholics located near White Swan on the reservation. Although this is a private, non-profit facility which serves the entire male population* of the State of Washington, both Indian and non-Indian alike, a high

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* SWARF, a companion parallel coeducational program offers similar services for Indian women who have problems with alcohol. SWARF is located at Vancouver, across the Columbia River from the Portland Area office.

percentage of its clientele are Indian, and most of these are from the Yakima tribe. This is probably not surprising, in view of its convenient location for Yakima tribesmen. The sobriety achievement factor of the Sundown M program is about 51% overall, and possible slightly higher for the Yakima tribe taken separately.

The involvement of IHS in the operations of this three to four week group home experience and therapeutic treatment center is well outlined in the following report:

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
PUBLIC HEALTH SERVICE
HEALTH SERVICES AND MENTAL HEALTH ADMINISTRATION

INDIAN ALCOHOL INITIAL TREATMENT CENTER

coordinated by:

Mental Health Office
Portland Area Indian Health Service

Sundown-M Ranch Corporation
Howard Kelleher, Director
White Swan, Washington
(for Indian men)

SWARF
John C. Soltman, Director
Office and Treatment Center
Fourth Plain at "0"
Vancouver, Washington
(for Indian women)

INDIAN ALCOHOL INITIAL TREATMENT CENTERS

Purpose: To develop regional in-patient alcohol treatment centers for Indian men and women as a first step in a comprehensive rehabilitation program.

Description: This is a project to develop a group treatment setting for Indian men and women within the existing treatment resources of the Sundown-M Ranch and SWARF Alcohol Rehabilitation Program.

The Mental Health Office of the Portland Area Indian Health Service will work with the directors of these two rehabilitation programs for the development of an initial alcohol rehabilitation program for Indian people. Selected Indian clients will be referred through their local tribal alcohol programs for an initial in-patient treatment period of 21 to 28 days. The initial treatment concept is based on the existing treatment programs and will consist of group and individual counseling, daily educational programs on the aspects of alcohol abuse, and coordination of comprehensive alcohol rehabilitation resources between the staffs of the treatment centers, tribally-sponsored alcohol treatment programs, and the Indian Health Service.

The development of these initial treatment programs will involve coordination of Indian Health Mental Health consultants and tribal Indian alcohol caseworkers in regular visits to the treatment centers. The comprehensive treatment program will be developed on the concept of Indian caseworker referral and coordinated follow-up by this caseworker in the patient's reservation community. The philosophy of an initial treatment center is the development of a setting in which Indian men and women can feel the presence of Indian cultural influences, receive counseling by Indian caseworkers, and have coordinated reservation follow-up.

REFERRAL PROCEDURE

I. Screening

The Indian alcohol caseworker should take the client to an Indian Health Service doctor or a contract physician.

The client must have a physical exam in the local community. The physical exam form should be completed by the examining physician in triplicate. Copies for: (1) the examining doctor, (2) the alcohol treatment center, (3) the Mental Health Office, 921 S.W. Washington, Room 200, Portland, Oregon 97205.

Acute detoxification must be done in a local hospital. The alcohol treatment centers are not acute medical treatment facilities. If detoxification is necessary, the client should be admitted to a local hospital for treatment, then transferred to an alcohol treatment center.

II. Referral

The Indian alcohol caseworker, local doctor, or local mental health consultant should clear all admissions through the Mental Health Office, Indian Health Service, Portland, Oregon. Please refer by telephone: A.C. 503, 226-3361, Extension 2420 or 2421. The Mental Health Office will arrange admission through the directors of the treatment centers. Office hours are 7:45 a.m. until 4:15 p.m., Monday through Friday.

III. Cost

Patient cost for the alcohol treatment center is covered by the Indian Health contract medical care services. Wherever possible, clients should be encouraged to apply for Public Assistance funding.

Transportation must be arranged locally through the family, a community resource, the tribal alcohol program, or the Indian Health Service.

IV. Names and Addresses

James H. Shore, M.D.
Miss Billee Von Fumetti, M.P.H.
Ashley Foster, Ph.D.

Mental Health Office
Indian Health Service
921 S. W. Washington, Room 200
Portland, Oregon 97205

Phone: A.C. 503, 226-3361
Ext. 2420 or 2421

James W. Dawes, Social Service Office — Ext. 1749

Richard Gaulke, M.S.W.

PHS Indian Health Center
P. O. Box 32
Toppenish, Washington 98948

Phone: A.C. 509, 865-3789

Sundown-M Ranch - Director: Howard Kelleher

Sundown-M Ranch
White Swan, Washington 98952

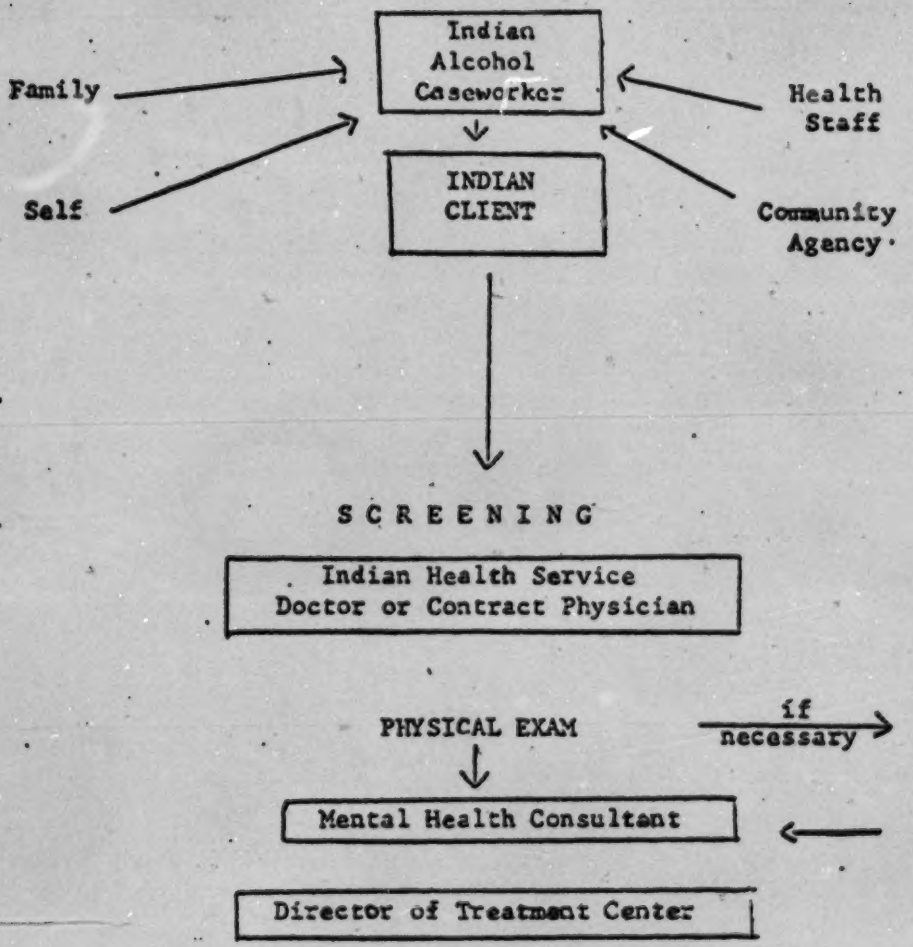
Phone: A.C. 509, 874-4915

SWARF (Southwestern Washington Alcoholism Rehabilitation Foundation)

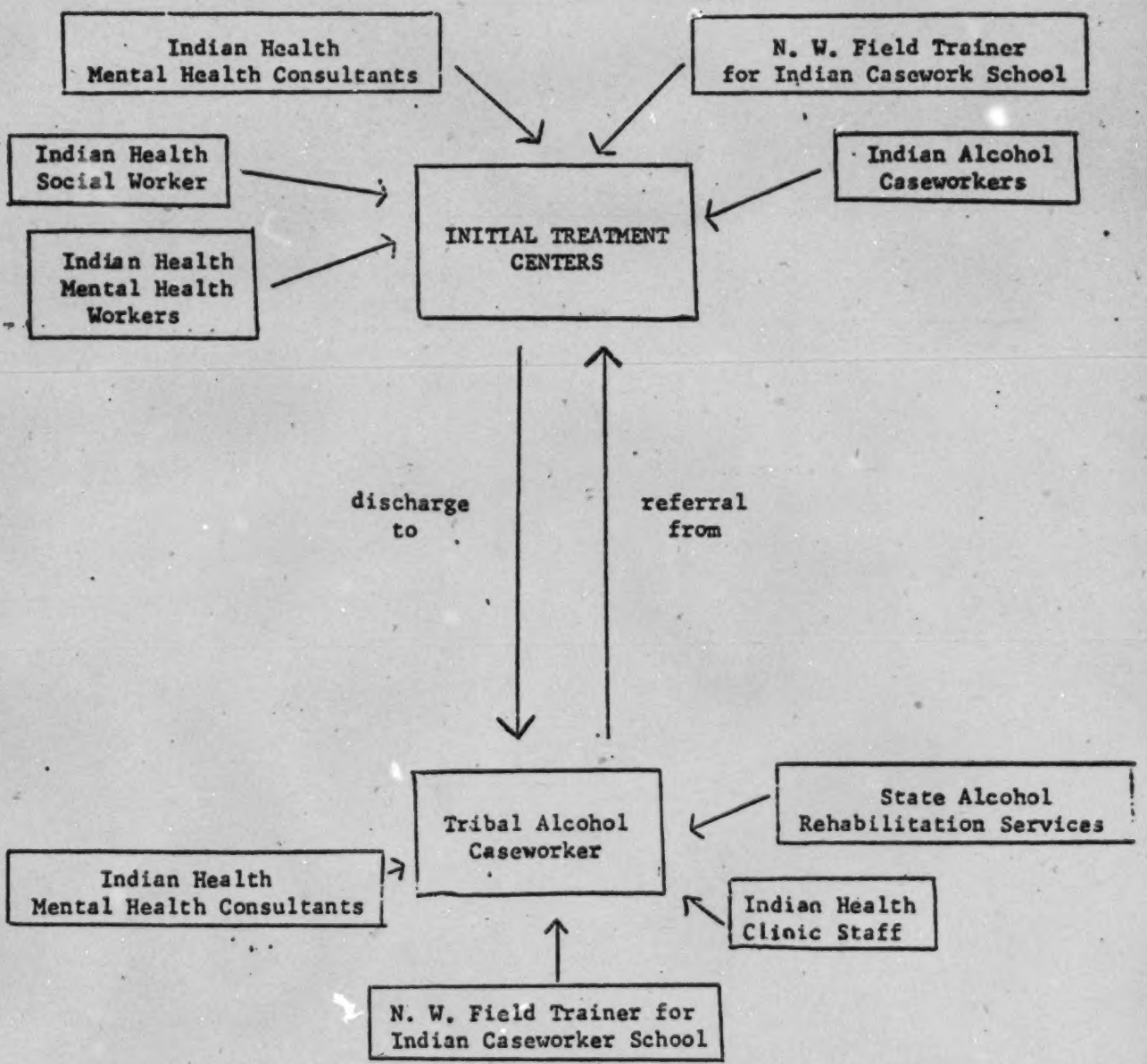
John C. Soltman, Director
SWARF
P. O. Box 1749
Vancouver, Washington 98663

Phone: A.C. 206, 696-1659

Referral Procedure



Coordinated Resources for the
Initial Treatment Program



PHYSICAL EXAM FORM

INDIAN ALCOHOL INITIAL TREATMENT REFERRAL

Sundown-M _____
SWARF _____

1. Patient's Name _____ 2. Address _____

_____

3. Sex 4. Date of Birth _____ 5. Date of Exam _____

6. Medical History:

Past History: alcohol withdrawal _____ DT's ___ Seizures ___ hallucinosis _
(check, if applicable)

7. Physical Examination:

TPR + BP
External appearance (tremulous?)
Skin (jaundice?)
HEENT
CV
Resp
GI (liver?)
Ext. M.S.
CNS

8. Examining Physician: _____ M.D.

Address _____ Phone No. _____

_____

9. Discharge date from initial treatment _____

Comments:

10. Follow-up by Indian Caseworker (Name) _____

Complete in triplicate: white copy for examining physician, blue copy for treatment center, yellow copy for Indian Health Mental Health Office (addressed envelope attached)

b. Colville Confederated Tribes (Colville Service Unit)

The Colville Reservation is one of the largest in area in the Northwest. The Columbia River marks its boundary on the East and South, the nearly right angle bend in the river is the site of the famous Grand Coulee Dam. Along its southern length the terrain of the Reservation is typically that of the Columbia Plateau. However, two thirds of the Colville Reservation lies in the Okanagon Range and other fingers of the Canadian Rocky Mountains. These mountains dominate the life, and especially the travel within the Reservation. For instance, Jr. and Sr. H.S. pupils attend one of three public school districts organized off the Reservation. A normal school bus round trip of 50 miles can and does often stretch to 75 or more miles when ferrys are not operating or icy conditions close shorter routes. A parochial school (elementary) on the Reservation has both boarding and day pupils for this reason, among others. Members of the Tribal Council and its active committees such as Health, Education, and Welfare may travel 80 or 90 miles to attend meetings.

Colville residents are proud of their very low suicide rate, but are unwilling to consider that it may be masked by a very high rate for serious injury and death due to accidents: They point out the hazardous roads and also the fact that if a car goes off the road in the mountains it may be days before a seriously injured person is found and helped.

Unemployment hovers chronically around 15-20% of the adult population. Lumbering is the main industry, with some employment available at the construction sites in connection with Grand Coulee Dam.

Tribal income derives in part from lumber and mineral leases, and in part in recent years from tribal enterprises such as acting as their own contractors for HUD housing projects, and in quite recent months

arranging to collect a fee for fishing and hunting permits along the lakes formed by the Grand Coulee Dam. This right has only recently been won in the courts and there are other suits pressing Indian claims to be free of state taxation on federal land which may improve the economic situation of many tribal members.

The Colville Confederation has many diverse opinions and until 1970 these polarized around the issue of whether or not to accept a lump sum federal payment and terminate their claims for federal services. A clear majority defeated the drive toward termination, and during the last four years the leadership has been making efforts to unite the factions. While differences remain, progress on a number of projects suggests generally improved morale.

In two years mental health services have grown to include a full time staff of two IHS employees: Nancy Melise, MSW of the Social Services Branch and Josephine Marcelly, MHW. Mrs. Marcelly is a former CHR and both her LPN and CHR experience have given her sound training and wide acquaintance with tribal members and their problems. In 1974 Mrs. Marcelly will be attending Evergreen State College as a candidate for a BA degree. Dr. Shore made Area Office consultation visits in the past and has been succeeded by Delores Gregory, M.D. who spends several days a month working with IHS staff and seeing patients.

One tribal activity centered around the week-long Chief Joseph days festival and encampment that is held annually at Nespelem in July. Unlike the Omak Stampede and Rodeo, or other non-Indian managed affairs, this is an Indian celebration where dancing, bonegames, camping and feasting are carried on amongst the people themselves. One of the frequently encountered problems to be sorted out during and following this festival had been the children separated from their parents. Sometimes the

parents were involved in accidents or illness and whisked off to the contract care hospitals. Sometimes they had become involved with the police for drinking or disorderly conduct. The usual result was the action of the police in taking the often quite small children, placing them in foster homes under the State Welfare system, or arranging in some other manner for their care off the reservation. The matters might have been better handled if the Colville Reservation had had its own tribal police, as is the case on many reservations, but the State of Washington does not permit this, and only sheriffs officers and state police may function unless a federal marshall happened to be present.

In 1973 the Mental Health staff decided to arrange for a special Teepee to be designated as both a first aid station and as the focal point for caring for lost children or those separated by circumstances from their parents and families. Many volunteers were enlisted to man the operation, and much publicity preceded the celebration itself. The involvement of all levels of agency and community groups was widespread, and there were regular announcements on the public address system of the location and services being offered.

The result was paradoxical. Not one child or infant was separated from its family during the entire week long celebration. Discussing the matter afterwards, the Mental Health team felt that the advance publicity not only alerted the tribe to the need, but also activated a sense of pride and responsibility on the part of those attending, so that they were particularly careful that their children would not need to utilize the shelter provided. From such triumphs are the frustrations of preventative mental health programs. For, although granting that this was the first and only year that such a good record had been made, how does one reinforce the volunteers who spent hours on call, or prove that the

presence of the program was in itself a preventative strong enough to be a remedy?

In general the total involvement of all factions on the reservation in policy making and the decision processes means a fairly slowly evolving series of practical solutions to long standing problems. Meanwhile the clinical services offered by IHS seem well used, and there is every indication that as the Mental Health programs become both visible and prove their usefulness, that they will become more involved in appropriate program consultation.

c. Spokane (served by Colville Service Unit)

Immediately adjacent to the Colville Reservation, on the East bank of the Columbia river, is the Spokane Reservation. This Reservation has a satellite health clinic manned from the Colville Reservation, and as the mental health program became established, the Colville team arranged weekly trips to Spokane in 1973 to offer their services and provide consultation for the physicians and nurses staffing that clinic. This has continued with the involvement of the Area Office Consultant, Dolores Gregory, M.D., on her regular trips to Northeastern Washington. At the end of 1973 a Spokane Mental Health Worker, Chris Sijohn, was recruited, and as he secures training and experience the trips by the Colville staff (but not those of the Area Office Psychiatrist) will be reduced.

d. Umatilla (Umatilla Service Unit)

The Umatilla Reservation, representing another confederated group of former horse culture Indians, is located near Pendleton, Oregon. In the planning that preceded the staffing grants for the Eastern Oregon CMHC the need for inclusion of services to the Indian populations was stressed, and consultant and clinical services by staff from Pendleton were arranged.

This enables the IHS staff to collaborate in offering the full range of services and to have clinical back up more closely available than could be provided by the visiting consultant from the Area Office. In many ways this program represents the Portland Area's best showcase for collaborative efforts with the non-Indian community. The attached summary of planning, prepared by a State of Oregon staff member indicates IHS involvement.

SUMMARY OF PLANNING FOR

EASTERN OREGON COMPREHENSIVE MENTAL HEALTH CENTER

Vast distances in Eastern Oregon, combined with sparsity of population, make delivery of services costly and difficult. Mental health is only one area in which there is a dearth of service. In many instances, there are no medical facilities in an entire county; and there is at least one county without a drug store. For a community to develop comparable educational and health facilities and services for the emotionally disturbed, the cost per capita for exceeds that of the more populous areas of Western Oregon.

In 1964, only one community mental health program was in operation in the entire catchment area of Eastern Oregon Hospital and Training Center -- the Outpatient Clinic of that hospital. Since that time, community mental health programs in six counties have come into existence: Baker, Harney, Hood River-Sherman-Wasco, Malheur, Umatilla-Morrow, and Union. Four counties still have no community mental health programs.

The Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, (Public Law 88-164), with amendments, made federal funds available for the development of comprehensive mental health services at the community level. The Act provides for a declining match of federal funds over an eight-year period for construction, if facilities are needed, and for staffing of the programs that are developed.

In November 1968, a two-day meeting at Eastern Oregon Hospital and Training Center brought together residents from the 13 counties of the catchment area for that hospital, as well as staff of the Community Mental Health Section of the Mental Health Division and the hospital. This group of interested citizens and professional people discussed the needs of the area and possible methods of implementing services to meet them. It seemed obvious that most of the communities -- and, indeed, counties -- would not be able to develop all the services in the field of mental health needed by their residents. Therefore, a decision was made that planning should be such that it included the development of comprehensive mental health services on an area basis, rather than county by county. With this approach, there would be access to the services

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by all the people; even though, in some instances, the services would be delivered in another county.

Planning has moved ahead on this basis. Now, after many meetings, a grant application is in the final stages of preparation. It will seek funds to provide a professional and technical staff to carry out the services which the planning group believes necessary to meet the needs of this population.

It is expected that the National Institute of Mental Health will classify this group of twelve counties as a poverty area, based on the total number of low-income families in the area. The advantage of this classification is that the first two years of the staffing grant can be funded with 90 percent federal funds; the third year with 80 percent; the fourth and fifth years with 75 percent; and the sixth, seventh, and eighth years with 70 percent. In other words, over the eight-year span during which this federal grant would be effective, the federal share of the salaries for professional and technical staff would not drop below 70 percent.

To achieve better services, this program provides the potential for many community agencies to affiliate with the comprehensive mental health center. There will be affiliations from two or three general hospitals that will be able to employ hospital staff to work with mentally ill, alcoholic, and drug-dependent persons. This will permit hospitalization of some persons in their local general hospitals instead of having to transport them to Eastern Oregon Hospital and Training Center.

Schools may also affiliate and thereby enchance both the number and quality of school counseling staff. Juvenile courts, treatment homes for children, and services on Indian Reservations will tie in to this administrative structure in such a way that a substantially lesser amount of local funds will be required to develop the services over an eight-year period.

Malheur County is not included in the planning for this comprehensive system of mental health services. Early in 1968, the Malheur County Commissioners requested planning which would develop coordinative and cooperative mental health services between Malheur County and those Idaho counties lying directly across the Snake River -- a natural service area. Many Idaho people use Oregon cities such as Ontario and Nyssa, as primary purchasing and service areas. Many people from Malheur County use Boise, Caldwell, and Nampa, Idaho, as their secondary purchase service areas.

Planning has proceeded which, if funded, will incorporate the mental health program in Malheur County into a coordinated program with five counties in Southwest Idaho. A grant application has been submitted to the National Institute of Mental Health. This does not mean that Malheur County will be giving up administrative control of that program

but, rather, that people from either state can seek service where it is most convenient and beneficial. Records of residence will be kept, so that adjustments can be made to ensure that neither state will be asked to assume financial responsibility for residents of the other state.

If the grant application for a comprehensive system of mental health services for these 12 counties (Baker, Gilliam, Grant, Harney, Hood River, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco, and Wheeler) and Eastern Oregon Hospital and Training Center is approved, the following additional services will be provided to the area:

1. A team will provide consultative, diagnostic, and some treatment services to counties which presently have no mental health services and will serve as the central administrative and consultative staff for the entire comprehensive system (Gilliam, Grant, Wallowa, and Wheeler Counties).

   The team will be developed from the "core" staff now included in the Mental Health Division budget as Eastern Oregon Outpatient Services (formerly Eastern Oregon Hospital and Training Center Outpatient Department). When this grant program becomes operational, the funds budgeted for this "core" team during 1972-73 will be used to match the federal funds to provide an increased staff to deliver the services listed above.

2. Inpatient services will be developed in Baker and Union, and possibly Harney, Counties. The only inpatient service now available in the area is at Eastern Oregon Hospital and Training Center.

3. Day treatment services will be developed for the five existing mental health clinics.

4. A sheltered workshop will be established in Hood River.

5. Residential treatment homes for children will be developed on the Warm Springs and Umatilla Indian Reservations. An outpatient mental health service will also be developed on the Warm Springs Reservation. These services will be funded by federal and local funds only, with no state funding.

6. Four Intermediate Education Districts will increase substantially the extent of counseling of school children through affiliation with the proposed center.

7. Specialists in alcoholism, drug abuse, and mental retardation will be placed in selected clinics.

8. A treatment progarm for alcoholics will be developed jointly by the Umatilla-Morrow Mental Health Clinic and Eastern Oregon Hospital and Training Center.

9. A residential treatment and day care center for children will be developed in La Grande.

10. A center in Harney County for alientated youth and drug abusers will be staffed.

11. Two full-time mental health professionals to work in the schools and the community will be provided in Gilliam and Wheeler Counties.

12. The inpatient facility at Eastern Oregon Hospital and Training Center will be improved to provide more intensive psychiatric care. These improvements will be concentrated in the admission and acute care sections of the psychiatric unit. Two new positions authorized for 1971-72 (Nursing Instructor and Institution Teacher) are included. Funds for these positions will thus be available for matching purposes.

As shown in the listing of services to be provided, implementation of this proposed mental health center will enhance the availability of services to this part of the state. In many areas, the center will provide the first mental health service ever available.

VI. WARM SPRINGS: HEALTH PROGRAM*

A. Description of Warm Springs Reservation

The mental health activities on the Warm Springs Reservation are unique in being directed by tribal council rather than by IHS. IHS does provide some of the funding and arranges for contract medical care when off reservation facilities are required, as well as providing consultation services. However, the planning and the carrying out of program activities is under the tribal administration. Because this is a very different arrangement than exists on any of the other reservations, a more complete description of the Warm Springs Reservation seems to be needed, as well as some observations about the usefulness of this model for IHS in other places.

1. Contemporary Characteristics

The following description is quoted from a report prepared for the Service Unit Director, IHS Indian Health Center at Warm Springs, Oregon for F.Y. 73. All descriptive material that is directly quoted in this section, unless otherwise indicated, is from this report.

The Warm Springs Indian Reservation of Oregon

The Warm Springs Indian Reservation is located in the north central part of Oregon, one hundred miles southeast of Portland, Oregon. The west boundary extends north-south along the summit of the Cascades Range, with the highest elevation being scenic Mt. Jefferson at 10,495 feet above sea level. Eastward, the land descends to a plateau between 2,200 to 2,600 feet elevation. The plateau is deeply dissected by streams which drain southward to the Deschutes River. Lower elevations to the east in fairly narrow stream valleys are 1,400 - 1,500 feet. Precipitation in the higher western area is thirty to forty inches annually; with the decrease in elevation to the east, precipitation diminishes to eight to twelve inches in the southern part of the Reservation. Vegetation is dense, primarily coniferous in the west, changing gradually to sage brush, juniper, and dryland vegetation in the east. Weather is generally mild, cold in winter, with approximately 120-140 growing days annually in the agricultural areas. Highway 26, which extends through the Reservation, in conjunction with the present local road system of 517 miles, allows transportation to reach a large part of the Reservation.

*Because it represents a distinctive and unusual arrangement, the Warm Springs tribal program will be presented here in detail. It is in many ways the prototype of successful tribally-organized programs which contract with IHS for specific clinical and consultative functions.

The Reservation consists of 564,329.55 acres, divided as follows:

Tribally owned	483,499.28
Allotted	80,814.25
U.S. Government	16.02
	564,329.55
Fee Patent Property within the Reservation boundary and in addition to amounts shown	4,218.29

Most of the Reservation is in Jefferson County (235,517 acres) and Wasco County (326,734 acres). The Reservation was originally established by Treaty in 1855. There are two settlements on the Reservation. The largest, Warm Springs, is located near the eastern boundary and has a population of about 1,500 people. Simnasho, 25 miles north of Warm Springs, has about 60 people. Population growth on the reservation for the period 1940 to 1969 has averaged approximately 3.25 percent annually. The reservation programs office, BIA, estimates that population growth will continue at around 3 percent annually. The nearest off-reservation city is Madras, Oregon, about 14 miles from Warm Springs.

Resources:

Timberland acreage exceeds 298,508 Indian and 351 private acres. Returns from timber harvest are the most important source of tribal income at present. The allowable sustained yield cut with intensive management has been established at 81 million feet annually.

Although the Reservation is in a rain shadow location, water contributes directly, as well as indirectly, to tribal income. Three dams on the Deschutes River (Round Butte, Pelton, and the re-regulating dam) operate under lease and contribute to tribal income. The streams and lakes in and on the border of the Reservation are utilized to some extent for irrigation and recreation.

Agriculture and range have, in the past, been a primary source of income for the Warm Springs people. Heirship problems, changes in wheat allotments, increased timber utilization, no range control, overgrazing by horses, the changing economics of farming on the national level, and other factors have caused a decline in returns from this resource. There are approximately 431,000 acres of grazing land (some multiple use in timber areas) and 20,000 acres of farmable land on the Reservation.

The recreation resource is on the threshold of realization. The lakes and streams support a limited sports fishery. The Tribes, The Bureau of Sports Fisheries and the Bureau of Indian Affairs have been developing data and initiating a management system which includes data gathering, habitat control, fish planting, and the installation of a proposed fish hatchery. The recently developed Kah-Nee-Ta Hot Springs Resort on the Warm Springs River is a successful, tribal-owned, luxury resort development which features a choice of unique recreations, an olympic sized, naturally heated swimming pool, and 340 days of sunshine per year. Kah-Nee-Ta Resort is planned to be the forerunner of a number of related summer and winter recreational developments to be initiated on the Warm Springs Indian Reservation. Construction of a $4.3 million expansion of the resort has just recently been

completed. The additional facilities includes a golf course with a pro shop, a deluxe convention lodge and restaurant, and a 60- by 80-foot swimming pool. An airport is planned for future phases of the resort development.

The major source of tribal income is from timber harvested on the Reservation and a 60,000 acre disputed area known as the "McQuinn Strip", and from the Pelton and Round Butte leased dam sites. The majority of the McQuinn Strip area is under federal control and has been in dispute status the past 116 years. The Warm Springs Confederate Tribes recently initiated a much more determined effort to reclaim the McQuinn Strip area. Last year tribal members approved by tribal referendum usage of $400,000.00 from tribal funds for purchase of 11,600 acres (homesteaded by non-Indians and which the homesteaders claim as their privately owned property) within the McQuinn Strip. Senator Packwood and Congressman Ullman have jointly sponsored a bill in the U.S. Senate which will allow return of the McQuinn Strip area to the Confederated Tribes. The bill has been submitted for committee hearings, and Senate consideration is still pending. Favorable action for the Confederated Tribes on this bill is expected in the near future. The tribal organization pays dividends to all enrolled members. Also, the Tribes now provide income through monthly payments from tribal funds to tribally enrolled senior citizens via a special tribal senior citizen pension plan. Earned income is derived primarily from logging and timber manufacturing, tribal and governmental payrolls, community commercial and service jobs, agriculture and range activities and commercial recreations. Some Indian families leave the Reservation during the summer months for seasonal agriculture employment.

The Tribe owns and operates a lumber mill and plywood plant. Estimated labor force breakdown by percentage of permanent jobs in each industry category:

Forest and Agriculture	33-35%
Construction	5-1/2%
Retail Trade	5-1/2%
Business and Repair Service	1%
Commercial Recreation	9%
Public Administration and Government	11%
Education	2%
Unemployed	33%

Cultural Factors:

On the Warm Springs Reservation, the median level of schooling completed is estimated to be eight years. The tribal education level is expected to be elevated with the coming year as more and more tribal members are seeking higher education, and many are attending technical trade schools. The Tribe has a scholarship program available to enrolled members for higher education. If the student completes his college course no repayment is required. An increasing number of students are taking advantage of this program.

The Confederated Tribes are descendants of three "main groups" - the Wasco, Warm Springs and Paiutes. The Taih, Wyam, Tenino and Dockspus bands of the Walla Walla are now known as the Warm Springs Tribe. The Dalles, Ki-gal-twal-la and Dog River Bands of Wascos are now known as the Wasco Tribe. A small band of Paiute was placed on the reservation after the southeastern military campaigns of 1866-68.

The Root Festival and Huckleberry Feast are traditional ceremonies preserved over the centuries and still are a part of the Warm Springs Indian life. As time for root gathering or huckleberry picking draws near, honored members of the Tribes dig the first roots in April and pick the first huckleberries in August.

All but a very few of the older Indian residents speak and understand English. A program to preserve the Indian languages by teaching it to younger members of the Tribe was recently instituted. Indian cultural courses have been started at the high school attended by Warm Springs students.

Religious denominations on the Reservation are Shaker, Full Gospel, Catholic, Presbyterian and the Indian Feather religion.

Utilities - Water and Waste Disposal

The majority of reservation residents live in or near the Agency area and are provided water and waste disposal systems administered by the Bureau of Indian Affairs and the Tribe. Rural homes are provided with these services through Indian Health Service construction projects. (For a detailed description of these projects see Environmental Health Services section.)

Communications:

The number of Indian homes with telephone service is negligible. The Tribal Police Department and BIA Forestry, Roads and Maintenance vehicles are equipped with mobile radio. Commercial radio stations at Bend, Redmond, and Prineville are received on the Reservation as well as four television channels from Portland. Television is by cable owned by Dan Macy. A monthly charge is made for TV service.

The Confederated Tribes in recent years have conducted an active housing program on the reservation. However, in January, 1969, a survey by the Bureau of Indian Affairs indicated there were 127 standard homes and 125 sub-standard homes in use on the reservation. Government housing provided for federally employed tribal people was not included in the study. Sixty-six new housing units have been constructed for Indian families since the survey. Increasing economic opportunities

on the reservation and maturation of the tribal population clearly indicate housing needs will expand sharply in the near future. The Tribe has been, and is continuing to negotiate with the Department of Housing and Urban Development for reservation housing assistance. Construction of fifty new homes through HUD is now underway in the Warm Springs West Hills Community. Needy tribal senior citizens and some tribal welfare families are provided with tribal housing without charge. Construction of fifty 1- and 2-bedroom apartments between the existing and additional Kah-Nee-Ta development is now available for resort employee housing.

Multiple family occupancy of dwellings is common.

The Warm Springs Tribal Council consists of eleven members. Eight are elected for three-year terms, and three are chiefs who serve as lifetime members. The chiefs are from each of the three Warm Springs Confederated Tribes. The Warm Springs Tribe is the largest, the Wasco Tribe is next in size, and the Paiute Tribe is the other tribe. The Council sets tribal policy and negotiates tribal business. A General Manager is delegated responsibility by the tribal council for tribal business administration. The tribe has a large administration staff which handles many matters ranging from financial to recreational. The Tribal Council appoints tribal committees for special tribal matters. The tribe has established its own education department, operates a loan department for tribal members, provides a welfare program for local tribal members, and sponsors its own tribal senior citizen pension program. Also, the tribe operates its own Law and Order Department with assistance from the Bureau of Indian Affairs, the state and the local counties. The Bureau of Indian Affairs has a large staff at Warm Springs to advise and assist the tribe with economic development, employment, timber management, social matters, education, realty, roads, special reservation programs, conservation and range management and other matters. The Oregon State Extension Service has a Home Economist and an Extension Agent assigned to the reservation. There is a relatively new Housing Authority on the reservation for handling HUD housing matters.

WARM SPRINGS INDIAN RESERVATION POPULATION DATA

AS OF JANUARY 1971

Enrolled, male	938
Enrolled, female	991
Total population (Age Distribution Available)	1,929
Enrolled, resident male	709
Enrolled, resident female	725
Total resident population (Age Distribution Available)	1,434
Resident, male (Indian enrolled and non-enrolled)	844
Resident, female (Indian enrolled & non-enrolled)	834
Total resident population (Indian enrolled & non-enrolled) (Age distribution not available)	1,678

2. Historical Perspective

This information gives a picture of a relatively prosperous tribe, with constructive programs in housing, education, minimum income, and employment, all characteristics which many other tribes seem to lack. Nevertheless, the Warm Springs Tribe still has a high unemployment rate (33%) and problems of alcoholism, disorganized homes, and early school leaving ages, all of which are indices frequently used of need for mental health services. In order to understand how the present program evolved, and how factors are interrelated, one must look more closely at recent tribal history.

One of the Tribal Council Members described the beginnings of the present day tribal programs. While not transcribed verbatim, the substance of his remarks are as follows:

> In 1939, when I was a very young man, we sat in the Council and we talked among ourselves. Other people owned our land. Some private homes surrounded our warm springs where we always liked to have our sweat lodge, and outsiders were cutting our trees and operating a sawmill and making the money that we needed. The farm land was sold or rented to outsiders. We were in very poor shape.
>
> We looked at our problems. They were much the same as they are now. Too much alcohol. Too many homes broken. Our children not getting the care and education they needed. No one had jobs and few houses were fit to live in. We could not do everything at once. So we made a plan, one thing at a time, and we began to work out ways to accomplish it. It would not do any good to dry a man up, have him sober from his drinking, and then have no job, no way to feed his family. In a few months he would be soaking up alcohol again. What else was there for him to do?
>
> Our first goal had to be to buy back our land. To get control of our own business and be able to provide the jobs people need. How we did it all I do not know, but much of it is on record in the Tribal offices. By 1959 we had back the Warm Springs and begun to build our resort. A place where we ourselves could enjoy ourselves, as well as tourists and Oregon people. By 1969 we had paid off the debt for the sawmill, and we owned almost every acre within our borders. It took a long time, but we managed it.
>
> Then, we began to turn our attention to these other things that we needed.

William Nichols, Director of the Tribal Health Program, which includes Mental Health, filled in one of the missing pieces. In an interview he tells how, in about 1969, the Warm Springs Tribe received a federal payment. Many tribes thought the United States were paying for land which had been previously taken either unlawfully or with underpayment for its value. In a great many tribes the monies were distributed in per capita payments to all enrolled tribal members. The Warm Springs Tribe were awarded a little more than $4,000,000.00 for the loss of their traditional fishing places when dams on the Columbia River flooded Celilo Springs. About one-half was distributed on a per capita basis. The mortgage on the Sawmill was payed off entirely, and the remainder invested. Interest is utilized for tribal projects, together with income derived from tribal industries.

3. Tribal Industries and Employment Practices

The major tribal industry is, of course, the sawmill and its associated lumbering in the mountains. Warm Springs is the leading producer of forest products of all reservations in the Portland Area. The second, and perhaps more well-known industry, centers around the Kah Nee Ta resort, which combines two facilities. The first built included not only a sweat lodge for tribal ceremonial use, but also an Olympic size pool, utilizing the naturally heated water. Cabins, suitable for family use, with the possibility of three bedrooms, two baths, kitchen facilities and living space are located near the pool. Each is capable of being subdivided into smaller units for single or double occupancy. Cement platforms, with fireplaces, provide the foundations for large teepees capable of providing sleeping space for ten campers. An excellent, moderately priced restaurant overlooks the Warm Springs River flowing through the reservation.

Wild horses have been tamed and broken to provide both riding in a ring and with guides over trails in the hills. A nine hole golf course is well cared for along the river banks.

A mile away from the original resort and on a hill overlooking the valley below a modern luxury hotel has been built, after a competition among architects for design which incorporated Indian themes. The result is a building which harmonizes with the setting, and in which even such details as the bolts of the beams in the rafters contribute to the effect. An indoor pool, gift shops, and gourment restaurant are managed by a Swiss hoteliere.

What makes the resort particularly pleasant is the use made of it by Warm Springs tribal families, who can afford to take their recreation here as well as provide it for others. Babies in cradle boards are propped in chairs at the table while parents and older children enjoy meals in the restaurants. Indian and white folk of all ages mingle in the pools and use the concession facilities. Indian organizations needing to hold conferences or meetings in the region also make good use of the facilities. Once a planned airstrip is completed, the accessibility of Kah Nee Ta should be improved to the point where it becomes well known, and the projection of future developments of ski lodges and other facilities are not unreasonable.

An interesting employment pattern has developed. The Tribe has not hesitated to hire outside expertise, but it also encourages its own members to serve apprenticeships and to secure education and training so that in time they will be able to take over complete management and operation of not only Kah Nee Ta, or the Saw Mill, but the business management of the tribe and the operation of its various service programs as well. However, they do not seem to make the mistake of presuming that jobs should be given to tribal members

regardless of expertise, ability or training. Thus the tribal payroll and government positions do not account for the bulk of the income on the reservation, and there is less difficulty planning and carrying out purposeful programs than on many reservations where Indian preference is such a high priority that competence is sometimes overlooked.

4. Tribal Health Program

The tribal health program illustrates this feature very well. At about the time when Dr. Shore began making consultation visits from the Area Office, the tribal leaders discussed with him the possibility of establishing their own Mental Health Program, and, Mr. William Nichols, MSW, was employed as its Director. Whether it was the observation already made by the tribal leaders or the result of an analysis made by Mr. Nichols in the first few months may not be clear in the records, but what is certain is that the high unemployment rate was analyzed and determined to be the result of alcohol abuse and emotional instability in a number of families. The first priority then of the tribe became the establishment of effective alcoholism counseling and treatment programs.

B. Alcohol Abuse Program

1. Justification

The justification for the program has been the finding that alcohol abuse was a contributing factor in 70% of the divorces, 67% of the suicide attempts, 85% of the job turnovers, 52% of the tribal court cases and 50% of the auto fatalities in 1970-1971. These facts are more extensively presented in the following report prepared as support for grant applications.

Alcohol Abuse - Warm Springs Reservation

Excessive drinking is defined as the consumption of alcoholic beverages to the point of drunkenness and habitual to the point of interfering in the person's functioning in some major area of his life. Those areas affected are: 1. Family life, 2. Employment, 3. Health, and 4. Relationships with the community.

Alcohol abuse is defined as the over-use of alcohol beyond the accepted social and medical norms of this culture. Violations of the medical and social norms are reflected in the arrests in the community and medical treatment for alcohol-related illness.

There is a number of people (statistics not available) on the Warm Springs Reservation who are chronic alcoholics as characterized by an inability to stop drinking once they have started and by major withdrawal symptoms when they do discontinue drinking. These symptoms are DT's, alcoholic seizures, and prolonged blackouts.

The predominant drinking pattern appears to be of the periodic binge type. The periodic binge drinker drinks from once a month to once a week, usually two to five days in duration. Drinking usually begins very early among teenagers (13 years, in some cases much earlier) and is viewed as a social and recreational activity. This attitude of drinking as a social and recreational activity is carried over into adult life.

The characteristics of the periodic binge pattern are:
1. Drinking on the reservation where it is legally prohibited, 2. Drinking from the bottle without mix or food, 3. Gulping drinks, 4. Aggressive acting out, primarily by fighting, 5. Group pressure to drink, 6. Drinking to escape problems and, 7. Drinking for oblivion.

Many of the people who drink in this fashion do not view this as a problem and continue to drink in spite of the numerous personal, social, legal, medical and social problems brought on by the excessive drinking. Some are looking for relief or escape from social, economic and personal problems. Such escape through the excessive use of alcohol is not possible and only compounds the problems and leads to further poor adjustments.

The problem of alcohol abuse manifests itself in the following ways in the Warm Springs Community:

1. Family Life: Excessive drinking by some of the Warm Springs residents has created a "drunken Indian" image among the

non-Indians both on the reservation and in the surrounding communities. The "drunken Indian" is characterized as being lazy, not employed, and drinking to the extent and frequency as his funds will allow.

Some of the children on the reservation have parents who provide a "drunken Indian" image. Too many times, these children copy the model established for them by their parents when they grow up and the problem repeats itself.

Excessive drinking is the leading factor in child neglect on the reservation. As of March, 1971, 40 Indian children from 18 different families were living in foster homes. Thirty-eight of these children or 95% of them were placed in foster care as a direct result of the mis-use of alcohol on the part of the parent or guardian.

Supervision and supportive care is being provided by the Jefferson County Welfare Dept. to additional 31 Indian children from 15 families. Ninety-three per cent of these children came to the attention of the Welfare Dept. as a result of misuse of alcohol. Other families have been brought to the attention of the Welfare Dept. and Child Neglect Committee, but no action was taken because of lack of resources or insufficient evidence of neglect. (Tri-County Child Welfare Services, Kerna, March 1971).

Excessive drinking by parents results in disorganized family life and is listed as a contributing cause in 70% of the divorces filed on the reservation in 1970. (Judge Thompson, Tribal Court, June 1971).

This same family disorganization is given as the major reason for placement in BIA boarding schools as public schools are available to all residents of Warm Springs. The rate of alcohol involvement is high in boarding schools as is the drop-out rate. of the 41 students enrolled in boarding schools, 34% dropped out. Chemawa reports that 77% of the dismissals in the first half of the school year 1970-1971, were related to drinking.

In 1970, there were 12 known suicide attempts reported to PHS, (it is felt that there were more incidents that went unreported), 67% of these occurred while the person was drinking. (Suicide report, annual PAO-PHS, 1970).

Employment. The present unemployment rate is 32% (March 1971). It is believed that an undetermined number of those who are presently unemployed are unable to hold jobs for any period of time because of chronic alcohol consumption.

Excessive use of alcohol results in unstable employment. Mr. Ed Manion, Manager of Ka-Nee-Ta resorts, states that he loses

an average of nine employees a month for reasons of "failure to show for work." Of this number, 85% were alcohol related. (Mr. Manion, July 1971).

Mr. Ken Jones, Engineer PHS for PL 121 projects reports that since 1964, when the projects began, that it was almost impossible to maintain an eight man work force consistently. The usual pattern was to work until pay day, then drink for several days. (Ken Jones, May 1971).

Statistics from the mill operations indicate that in the period from 10-69 to 4-71 there were 198 turn-overs at the mill. Of this number 63 terminated voluntarily for such reasons as: other job, school, job completed or death. One hundred fifty-five terminated for involuntary reasons. Of this number, 100 were terminated for "failure to show for work," 8 for being in jail, 6 for family problems, 4 for "unable to do the work," 2 for "drunk on the job," 2 for poor workman, 2 for sleeping on the job and 6 gave no reason.

Of those terminated for "failure to show for work," the majority had been drinking. of the 155 terminated for involuntary reasons, 69 worked for less than one month. (BIA Employment Statistice 4-71).

Health. The medical officer at the Warm Springs Health Center estimates that 5% of the clinic visits during regular clinic hours are people who are seriously impaired in their functioning because of alcohol. Of the estimated 900 after hours clinic calls, 85% are a direct result of excessive drinking (Dr. Leland Reamer 5-71).

The following information was taken from the Ambulatory Patient care records maintained by PHS-PAO.

Warm Springs - Alcoholism cases treated.

For the period ending	Total	First Visits
Sept. 1970	21	4
Dec. 1970	46	7
March 1971	34	6

The majority of these cases were in the age range of 45 to 64 years of age. (Ambulatory Patient Care Report, July 1971).

Community Relationships. There was a total of 459 cases in the Warm Springs Tribal Court in 1970. Of this number 65 were minor traffic violations, livestock and game offenses. This left a

total of 394 cases of which 208 were alcohol related offenses. This is 52% of the criminal cases tried in the Warm Springs Tribal Court. Judge Thompson of the Tribal Court estimates that more than half of the law and order budget is spent on arresting and confining alcohol involved cases. (Warm Springs Tribal Court records and Judge Thompson, May 1971).

Mr. Mark Werner, BIA Probation and Parole Officer, estimates an additional 300 alcohol related complaints were made to the Tribal Police Dept. that did not require court action.

Judge Nelson of the Justice of the Peace Court in Madras, reports that of all the alcohol related offenses handled in his court, 90 to 95% were individuals from the Warm Springs Reservation. Many of these offenses, 25% were repeat violations by specific individuals. (Phone conversation with Judge Nelson, 6-71).

Judge Herschel Reed of the Jefferson County Juvenile Court in Madras reports a total of 112 liquor violations in 1970 committed by juveniles under the age of 18. Of this number, 42 or 37% were committed by Indian youths. (Phone conversation with Judge Reed 7-71).

There were 8 deaths of accidental nature on the reservation in fiscal year 1969-1970. This includes auto accidents. Thirty-seven to 50% of these accidents involved alcohol.

Reliable statistics are not available on the number of alcohol involved personal injury accidents for the past year.

2. Plan of Program

The plan of attack developed for the Alcohol Abuse Program was to develop a roster of high risk individuals from the various community agencies such as law enforcement, courts, Health Center, employers and tribal committees concerned with child neglect and alcohol abuse. These persons were given opportunities for counselling by two counselors, hired and trained in the special techniques of working with this population. These counselors became advocates assisting their clientele in solving many basic problems as well as in controlling their alcoholism.

A widespread educational program in the community and schools was also mounted, stressing not only the problems caused by abuse of alcohol, but also the resources available and the program offered by the tribe to help solve basic problems. Links were established with resources that were needed. These ranged from the medical supports needed from IHS to contract hospital facilities for detoxification, and other state and federal programs such as Sundown M and SWARF, and private alcohol rehabilitation facilities. The counselors were charged with follow-up activities in seeing that these resources were used appropriately, and that needed medical and social services were properly requested and used by the persons in need.

The major lack of this program has been local detoxification facilities. The nearest hospital, fourteen miles from Warm Springs, has an ambivalent attitude toward admitting this type of patient. At times local jails, homes, and similar facilities have been utilized, with family and volunteers supplementing the staff. As the program began to establish a reputation, tribal members from as far away as Seattle would request help, and return to Warm Springs to participate.

One striking advantage to being a tribal operation has been the ability of the tribal council to establish a policy that all residents of the reservation should be served. This includes IHS and BIA staff who are not always immune to the disease of alcoholism, as well as employees of the sawmill and [illegible] businesses. As remarked by Mr. Delbert Frank, one of the counselors, "If we have these people for neighbors, and must live with them, we must take care of them as well. Otherwise they remain a source of infection for all of us." It has become policy that no one may be discharged from a job simply because of suspected alcoholism or even for obvious signs of drunkenness and

inability to work. First the individual must be referred to the Alcoholism Counseling Program. If the referral is refused, or if the counselllors find that they are not successful in helping the individual concerned to stay sober, then discharge from employment is approved.

Multiple funding sources, including federal alcoholism programs as well as tribal monies, have been utilized and the program seems to be well established at this time.

C. Children's Group Home

1. Need and Justification

A second high priority of the tribal council was the solution of a long-standing problem with regard to children. While child battering and child abuse was almost completely unheard of on the reservation, a relatively high number of children were found neglected, usually without knowing where their parents were. Three hundred of the eight hundred children under the age of eighteen were arrested or seen in juvenile court during 1970. While many were returned to their homes after two or three days, little was done to alleviate the conditions that had led to their neglect or delinquincy. Furthermore, a substantial number of children each year were placed by state agencies in foster homes away from the reservation, to institutions, and were seldom able to be returned to their families.

In a recent report Dr. Shore and Mr. Nichols document that during 1972 two hundred nineteen, or 28%, children under the age of eighteen were not living with their natural parents. Seventy-four of these were in foster care placement with the State's Children's Service Agency. For a variety of reasons, the state agency did not license Indian foster homes on the reservation, and once a child was placed away from his or her community, there was almost no

follow-up service available to the family. Although parental behavior was often interpreted by the state agency as indifferent or neglectful, and the continuing or intensification of alcohol abuse offered as proof of unfitness, the tribal committees saw these events in a somewhat different light.

There was strong feeling that once the children were gone there was nothing to hold the home together and no real motivation to solve the problems which had led to the charges of child neglect and the predicament of the youngsters. The same kinds of reasoning applied in many ways to the children who were sent to boarding schools away from the reservation, since educational resources were available locally for families which remained intact.

2. Tribal Involvement

Unlike the situation in Washington, the State of Oregon permitted the jurisdiction of tribal police and tribal courts on reservations. The State could also recognize a program completely operated within the reservation even though it did not license individual homes. Therefore, the Tribal Law and Order Committee requested, in 1972, that a group home of a therapeutic and rehabilitative nature be established which would accomplish several objectives at once:

> Provide an alternative to jail for known delinquents with a preventative and individualized program
>
> Provide a shelter for the care of dependent children
>
> Provide therapy for emotionally and behaviorally disturbed children
>
> Provide counselling and, if needed, psychotherapy for the parents or substitute parents of these children
>
> And in all its activities facilitate a successful return of the child to his family

There is an interesting anecdote told of the discussion of this project in the Tribal meeting. An interpreter who was asked to explain the proposal is recalled to have reminded the older members that traditionally the tribe used to select one of its wiser members to be the "Whipper Man," and administer proper discipline to those youth and children who showed disrespect for their elders and the proper ways of doing things. He suggested that the group home program was a modern equivalent and would endeavor to bring children up in ways that were proper. It is not clear from those who relate this anecdote whether the "Whipper Man" also ajudicated family quarrels and made use of the opportunity to admonish parents as well as children. Such a role would not be out of keeping with similar traditional figures in other tribes.

What is clear,is that the tribe in council and the program staff in its actions, are acting with the sanction of tradition as the agent of the eldest and wisest of the tribe's members. The continuity of context between old and new ways is very real and accounts for the high degree of parental acceptance of the program.

3. NIMH Funding

After tribal discussion and approval, an application was made to NIMH. The project was funded for an eight year period beginning in January 1973. A Director was chosen, Al Schmaedick, who is an M.S. psychologist experienced in working with mentally and behaviorally disturbed children in and out of residential settings and as a counselor for jail and courts.

Goals were established as follows:

1. Reduction of juvenile arrests and recidivism by 15% in the first year and 50% over five years.
2. Adequate shelter for dependent children.
3. A reduction of at least 50% in the number of children to be placed off the reservation.

This was to be accomplished by maximizing the juvenile's contact with his community while providing him with a new base within it. Involving the family to increase the chances for a successful return home and maintaining continuity of education by keeping children in their own schools were essentials of the plan.

Initially, it was thought that a wing of the jail could be utilized for a holding facility, and quarters added to that building; but before any children were involved, it was decided to develop the program in seprate quarters. Until these could be built in space adjacent to the IHS clinic, the facilities of the Presbyterian Church were made available.

By the spring of 1973, additional staff had been hired and were engaged in an intensive training program. Another funding source had been added, allowing some discretion in the use of the NIMH funds and an increase in the number of staff and their duties. An extensive outpatient or field services program was established, as well as the residential program. A Child Psychiatry resident from the University of Oregon Medical School was made available as a consultant.

4. Progress Report

It is probably easiest to let the report of the Director speak for itself, as it was submitted in April 1973, five months from the initiation of the program and two months after it had first begun accepting children.

Warm Springs, Oregon
Tribal Children's Program-Ext. 73

TRIBAL CHILDREN'S PROGRAM
The Confederated Tribes of the
Warm Springs Indian Reservation
Director, Al Schmaedick

PROGRESS REPORT
April 5, 1973

On April 3, 1973 construction was started on the new Tribal Children's Group Home. The contract went to a local contractor, Mr. Larry Runge. The building will be built on location rather than being built as a modular home as previously discussed. However the contractor has promised a sixty day completion date with a penalty written into the contract if he does not complete the project on time. The floor plan for the building has not been changed, therefore as previously discussed we will have an eight bedroom home with approximately 3,000 sq. feet of floor space. The location will be adjacent to the present Day Care Center.

For the present we continue to operate out of the Presbyterian Church. Reverend Cal Chin had agreed to continue making this building available to us for the price of the utilities for the building. This has averaged about $80.00 per month to date and of course this cost should go down with the change in the weather.

We have started another segment of our training program for all staff. This involves participation in a college level calss on Child Development being offered through Central Oregon College and the Tribal Education Office. Also we have two workshop days set up with Dr. Dennis Frisby, a Child Psychristrist from Portland. We are also negotiating a class in Interviewing Skills through Central Oregon College and D. C. E.

There have been some changes in staff, therefore I will again list all the people who are presently working for the Tribal Children's Program. They are as follows:

Al Schmaedick	Program Director
Larry Calina	Treatment Coordinator
Marcia Soliz	Administrative Secretary
Verbon Greene	Field Counselor
Urbain Manion	Field Counselor
Arlene Boileau	Field Counselor

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Barbara Yaw	Field Counselor
Uren & Gwen Leonard	Child Care Worker II
Scott Remington	Child Care Worker I
Oliver Kirk	Child Care Worker III
Redine Kirk	Child Care Worker III
Ramona Tanewasha	Child Care Worker III
Douglas Williams	Child Care Worker III
Ernestine Stevens	Child Care Worker III
June Cochran	Part-time Child Care Worker Aide
Deborah Williams	Part-time Child Care Worker Aide
Mildred Kirk	Part-time Child Care Worker Aide
Andrea Schmacdick	Part-time Child Care Worker Aide

We continue to provide services and the demand for services is ever increasing. We are finding now that people are coming to us rather than us having to seek them out. I feel that this is an encouraging sign meaning that our program is being accepted quite well by the community. I have initiated marriage counseling with three couples within the last two weeks. I am doing this in conjunction with the field workers. This provides the benefit of training a worker and at the same time it establishes a highly effective therapeutic team approach.

The following dat will serve to bring the reader up to date as to actual services provided.

OUT-PATIENT SERVICES	Month of March	Total for Year
(1) number of new family referrals	26	79
(2) total number of persons being counseled	33	120
(3) number of sessions held with or in regard to clients	233	455
(4) number of hours spent in field work	397	696
(5) approximate mileage of field workers	2028	4228
IN-PATIENT SERVICES		
(1) number of children admitted to temporary group home	34	63

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Tribal Children's Program-Ext. 73

(2) average number of days children stayed in home	2	5
(3) peak number of children at one time	17	34
(4) present number in residence	7	15
(5) number of children placed off reservation	0	1
(6) number of children placed in foster homes on reservation	7	9
(7) number returned to own home	20	38

5. Achievement of Criterion Goals

Further data, secured after eight months of the operation of the Group Home and its outreach program, indicate that 149 children have been involved from ninety-eight separate families, representing about 20% of all reservation families. 90% of the placements in the Home represent problems related to excessive drinking by the parents, making a close association with the Alcohol Abuse Program essential. Fortunately, both are under the same overall direction, and work can easily be coordinated.

The other 10% of the placements involved juvenile delinquency, runaway actions, or as an unexpected bonus, severe medical problems. Four children could live at the Group Home while receiving intensive and extensive medical treatment as an alternative to hospitalization in a distant city.

It is too soon yet to measure the program against the high statistical criteria it established for itself. However, the reduction in children placed off the reservation has certainly been reduced by more than 50%. 40 children were so placed in 1971, 30 in 1972 and 1 in 1973.* The only child placed since the Group Home opened was already officially in the custody of the state, and there was no legal recourse available to work out another solution. Information on the delinquency rate has not yet become available.

D. Multiple Problem Family Project

1. Description of Need

In January of 1973 still a third program was established which would extend the experience gained in the alcoholism and Child Care (Group Home) programs to include concentrated attention to multiple problem families.

* 0 in 74 and through May 75

The problem is stated succintly in the program report of the director for fiscal year 1973:

> There are a number of families on the Warm Springs Reservation that are subject to severe stress from several sources. When this stress becomes extreme, the family ceases to function as a unit. The exact number of these families has not been established, as only the symptoms present themselves in the community. These symptoms are:
>
> (1) Excessive drinking (see alcohol abuse emphasis plan)
> (2) High divorce rate (30 in 1970)
> (3) School drop-outs (34% in boarding schools, 20% in public schools)
> (4) Unemployment (37% in 1971)
> (5) Delinquency (121 referrals to the tribal court in 1971)
> (6) Suicide (6 attempts in 1971)

The objectives of the program will be to establish a high priority service file on families that are known to more than one agency, to provide counselling services to these families, and to establish suitable prevention programs.

2. Plan of Action

The plan of action for this program, and the means by which it will be self evaluated by the tribal committees, are copied from the Director's report on the following pages.

c. Plan of Action:			d. Evaluation:		
(1)	(a)	Meet with representatives of agencies providing services to the reservation population and with local committees and community groups to discuss the problems of families.	(1)	(a)	Have meetings been held with representatives of agencies and community groups to identify sources of stress on families?
	(b)	Establish a high priority file on families known to more than one resource.		(b)	Has the high priority file been established?
(2)	(a)	Contact high risk families to offer counseling and assistance.	(2)	(a)	Percentage of high risk families contacted and offered assistance?
	(b)	Refer to appropriate agencies for specialized services.		(b)	Number of referrals made for specialized services?
	(c)	Assist families in following through with the referral and provide needed follow-up support.		(c)	How have families responded to referrals made?
(3)	(a)	Identify the major problems that create stress on the family units.	(3)	(a)	What problems have been identified?
	(b)	Establish an education program to inform the community of these problems and alternate ways of dealing with problems.		(b)	Has an education program been developed?

III-9

c. Plan of Action:	d. Evaluation:
(c) Enlist the assistance of the Tribal Council, Tribal Committees, Public Health staff, BIA staff and other concerned individuals in modifying conditions in the community that create stressful situations for families.	(c) What conditions have been identified in the community that create stress on the family? What action has been taken?
(d) Develop individual emphasis plans for major problems as they become identified.	(d) Have additional emphasis plans been developed?

3. Preliminary Indicators of Effectiveness

This program has been too new to secure reports on its effectiveness. However, work with a typical case was observed during the summer of 1973. A recently divorced couple had divided custody of the children, daughters with the mother, infant son with the father. Counselors were attempting to aid both parents and children in handling the emotional stress involved in the separation and the visiting. The mother was receiving concentrated help with the Alcohol Abuse Program as a condition for further education or employment. The father had arrangements made for housekeeper services and the use of the Day Care Center so that he could continue his employment and maintain a home for his son. Realistic credit counselling and discussions with the housing program were underway. The father was being helped to pay off a fine rather than have to serve a term in jail and not be able to keep up with his family obligations.

The multitude of problems was indeed overwhelming, and the staff conference indicated that each family member had some advocacy, and a lot of understanding and support as the team coordinated inter-agency efforts to bring some order into the chaos. While the problems involved seem Augean, this link between parts of the Mental Health Program itself, and with other agencies is probably one of the most essential ones in the chain of treatment and preventative programs being developed.

One factor that looks toward the future is the built-in determination to attempt to discover underlying causes and to build on this research new patterns of preventative as well as treatment services.

E. Major Mental Illness

The only component of the program not originating with the tribal committees has been the plan to search out those on the reservation suffering from major mental illness and develop treatment plans for them. Mr. Nichols, in an interview during the summer of 1973, pointed out that the same overly tolerant attitude toward deviant behavior that could allow an alcoholic to destroy himself, applied to bizarre behavior. Persons with schizophrenic symptoms were permitted to be bizarre, but were shunned until some crisis arose. The discovery of one or two such individuals, and the successful treatment of at least one, was arousing interest. The possibility that the behavior might be due to a treatable illness, and not a free choice, is apparently both a new idea and possibly a relief to the concerned members of the families.

Since the number of such individuals is unknown, the first step of the problem is to identify persons incapacitated by mental illness through a promulgation of concrete descriptions. Reports of bizarre or unusual behavior that come in to any of the staff from family, friends, and community residents will be noted. Similarly referrals from the IHS physicians, local private physicians, and hospitals will also be evaluated. Courts, Law Enforcement agencies and the Tribal Committee will also be asked for referrals.

Each person referred will be given psychiatric examination, probably by the IHS consultant staff, and appropriate treatment programs should be developed. Where state hospitals are involved or private psychiatric facilities, complete reports will be requested and follow-up services arranged.

A separate staff had not been established for this project in 1973. However, the Director was taking a personal interest, and it seemed unlikely that any of the staffs of the other three programs could remain long uninvolved

in making the discriminations between stress reactions, other forms of behavior, and major mental illness among their clientele.

F. CHR and MCH Aides

Mr. Nichols directs the Tribal Health Programs as well as the four components listed above. He has direct charge of the Community Health Representatives and the Maternal and Child Health Aides who function in roles not very dissimilar from those with similar titles onother reservations. The difference here may well be that the clarity of their function is more easily established because they are linked directly to a complex of Mental Health Services as well as to the Tribal Council and the IHS staff.

G. Coordination of Total Program

This coordinating function is best shown on the three accompanying organization charts. One shows the formal programs under the jurisdiction of the Director and indicates where known the budgets of each as a total of multiple funding sources.

The second shows the tribal organization chart, showing the health program in its place amongst other tribal departments. The third shows the IHS Service Unit chart, indicating the presence of the Tribal programs without the lines of IHS authority.

Mr. Nichols has an office in the Health Center and provides direct clinical services as well as coordinating Mental Health programs and resources. His functions as seen by the SUD are described below.

MENTAL HEALTH

A. Day-to-Day Services

1. Direct Services

The Mental Health Director is an employee of the Confederated Tribes through contract funds provided by PHS. His office is located in the health center.

Patients are referred for individual, marital and group counseling through:

a. Self-referral
b. Referral from health center staff
c. Referral from tribal court
d. Referral from BIA Social Services
e. School referrals
f. Child Neglect Committee
g. Tribal Health and Welfare Committee

2. Coordination of Mental Health Resources

The Mental Health Director serves as the coordinator for the mental health personnel from the Portland Area Office. This consists of making appointments with patients and arranging for special communit or agency meetings. He is also available to any agency or community group for health and welfare meetings as a resource person.

3. Program Development

The Mental Health Director is a member of an advisory committee which is responsible for:

a. Identifying mental health needs.
b. Writing grant proposals for necessary treatment, training and education programs.

B. Emphasis Plans - Mental Health
1. Assessment of Needs
a. Statement of the Problem
At this time, this service unit does not have an effective mental health program to survey and assess the mental health needs and develop suitable programs.
b. Objective:
(1) Identify the nature and extent of the reservation mental health problems.
(2) Reduce the incidence of emotional and mental illness.
(3) Develop comprehensive mental health programs.
c. Plan of action:
(1) Identify the mental health needs of the reservation through consultation meetings with individuals, community groups, and representatives of tribal, Bureau of Indian Affairs and health center staff.
(a) Review available statistical data compiled by such agencies as: Tribal Court, Child Neglect Committee, Employment Office, Social Services and Health Center to identify mental and emotional problems.
(b) Conduct special surveys to gather data on problems that will require special emphasis, i.e., alcoholism, child neglect, family instability.

(2) Provide individual, group, marital and community counseling services to persons referred.
   (a) Develop mental health resources both on and off the reservation.
   (b) Provide consultation services to individuals and groups who are the primary contact with the patient in the community, i.e., Community Health Representatives, Public Health Nurse, Tribal Health and Welfare Committee.
   (c) Conduct education programs in the community on mental and emotional health problems and how to recognize them.
   (d) Work closely with local school personnel to assist in the early identification of mental and emotional problems and developing an effective treatment program.
   (e) Coordinate and initiate mental health services available through Mental Health Office, Portland Area Office.

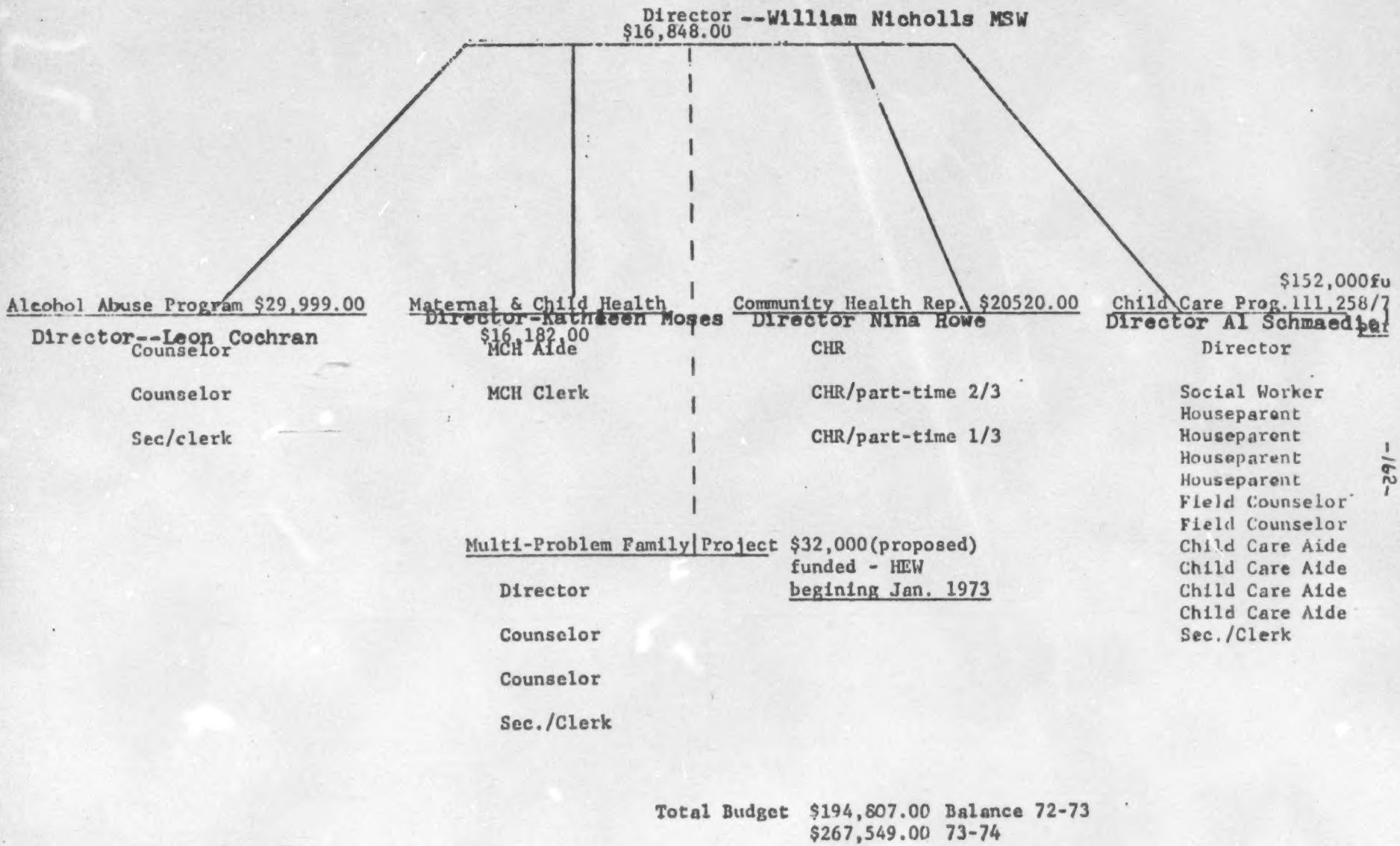
(3) Assist in forming a Mental Health Advisory Committee composed of residents of the community.
   (a) Assist Mental Health Advisory Committee in writing grant proposals to secure needed funds for training, treatment and education programs.
   (b) Develop mental health resources through regular consultation with representatives of Portland Area Office, Federal, State, County and local agencies.

d. Evaluation:

(1) Are consultation meetings being held to identify mental mealth problems?
   (a) Is statistical data being obtained and reviewed to determine the extent of the mental health needs?
   (b) Are special surveys being conducted to gather additional data on problems such as alcoholism, child neglect and family instability?

(2) Are direct counseling services being provided for those persons who have been referred?
   (a) Are new mental health resources being developed?
   (b) Are consultation services being provided to primary contact persons?
   (c) Are mental health education meetings being held in the community?
   (d) Has contact with school personnel led to early identification of mental problems and assisted in effective treatment planning?
   (e) Are Portland Are Office mental health resources being used effectively?

WARM SPRINGS TRIBAL HEALTH PROGRAM



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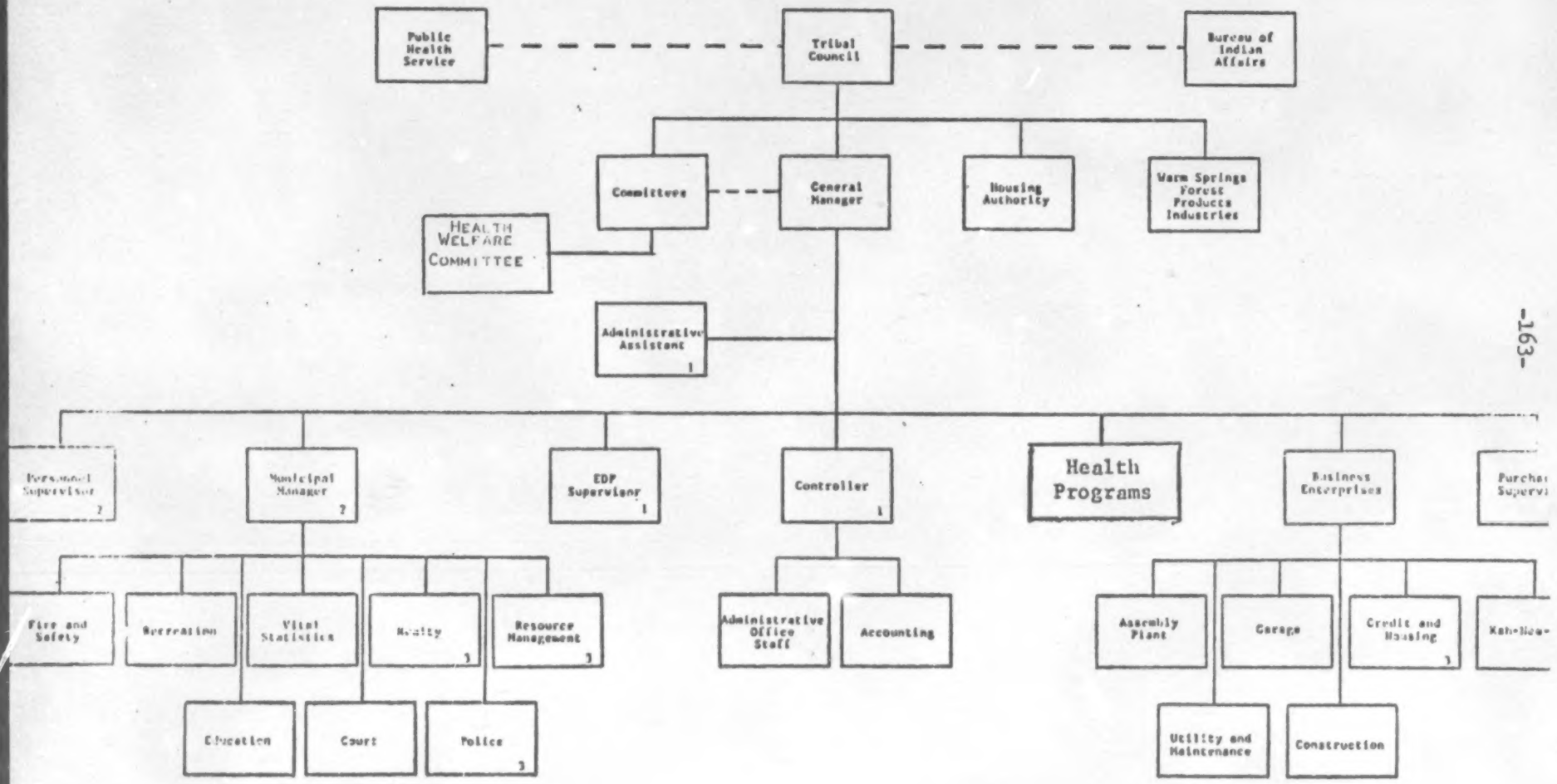
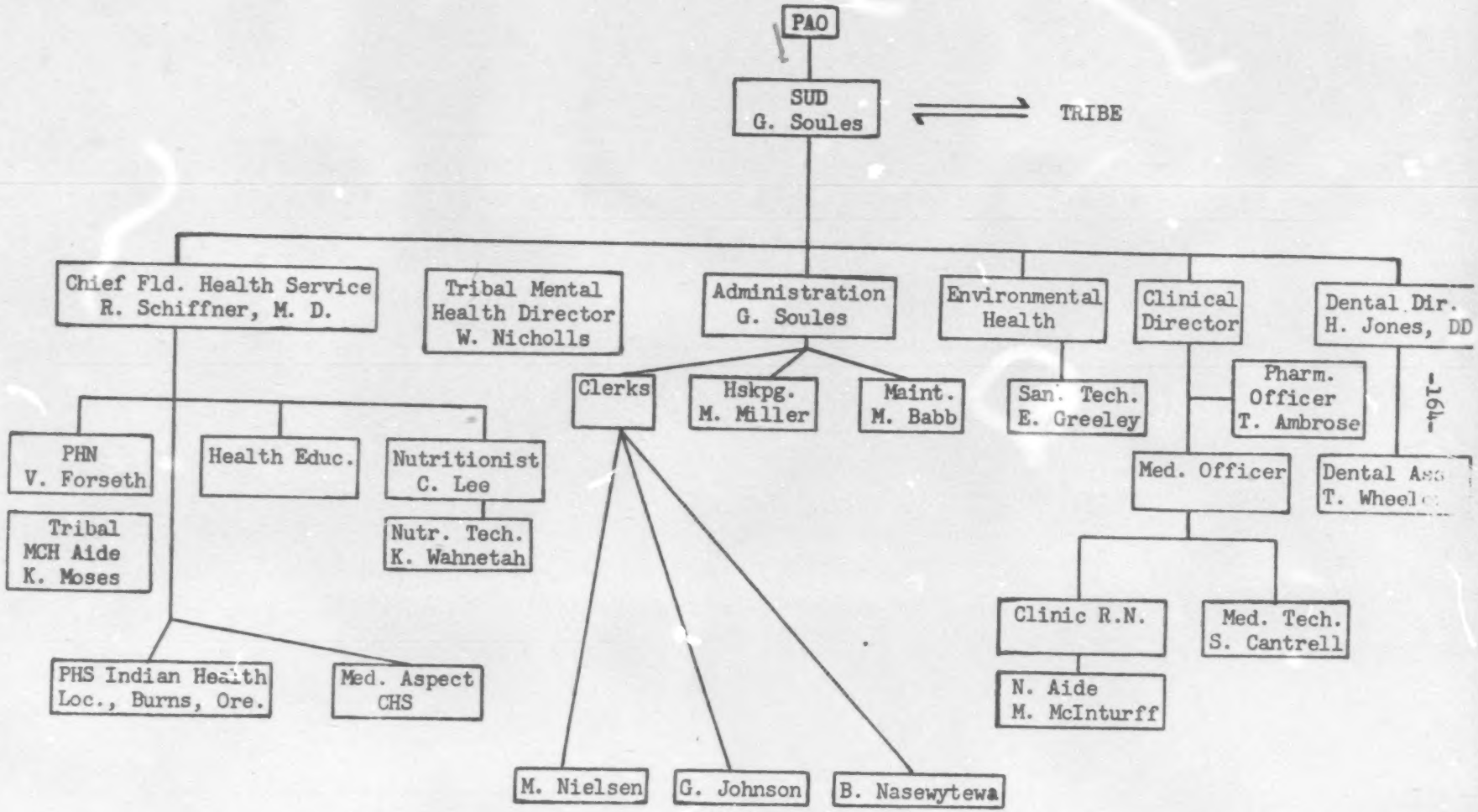
Total Budget $194,607.00 Balance 72-73
$267,549.00 73-74

ORGANIZATION CHART



1. Appointment to position to be made in 1971.
2. Appointment to position to be made in 1972.
3. Position presently held by Civil Service (BIA) employee.

Date approved
7-12-71


PAO
SUD
G. Soules
TRIBE
Chief Fld. Health Service
R. Schiffner, M. D.
Tribal Mental
Health Director
W. Nicholls
Administration
G. Soules
Environmental
Health
Clinical
Director
Dental Dir.
H. Jones, DD
Clerks
Hskpg.
M. Miller
Maint.
M. Babb
San. Tech.
E. Greeley
Pharm.
Officer
T. Ambrose
PHN
V. Forseth
Health Educ.
Nutritionist
C. Lee
Tribal
MCH Aide
K. Moses
Nutr. Tech.
K. Wahnetah
Med. Officer
Dental Ass
T. Wheel
PHS Indian Health
Loc., Burns, Ore.
Med. Aspect
CHS
Clinic R.N.
Med. Tech.
S. Cantrell
N. Aide
M. McInturff
M. Nielsen
G. Johnson
B. Nasewytewa

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v

The emphasis on need for epidemiologic data has been discussed with Mr. Nichols in an interview, and he is very interested in developing a broadly based study of the reservation population. However, this will need to be planned in response to the feelings on the part of the Tribal Health and Welfare Committee and Council that they wish to know more about the specific needs of the tribe and its communities. As the initial projects gain stability, and as interest in measuring their effectiveness is developed, one can expect the tribe to recruit consultants to further analyze the needs and to develop proposals for meeting them. Some groundwork for this has already been laid in the insistence upon evaluation questions attached to each program objective and plan of operation as well as in field studies of available sources of information completed by graduate students from the University of Oregon. Within the next year or two real involvement of tribal people in assessment of program effectiveness and in searching out unmet needs can be expected.

H. Characteristics Basic to Success

The emphasis on tribal involvement in directing these programs is essential. One of the underlying reasons for the high level of morale of staff and the stability of program developed has been the fact that 90% of all staff are tribal community people, and that with the exception of the identification of persons with major mental illness, the program foci and format have been of tribal origin and choice. Mr. Nichols, in reminiscing about his early days on the Resevation, did recount the necessity he faced in the beginning of clarifying repeatedly his role as a tribal rather than a federal employee. He has been especially skillful at avoiding the trap of taking charge, and of allowing - probably more accurately being given by

default - the credit and blame for program success. He continually utilizes his energies and expertise in the service of the Tribe, facilitating the achievement of their own goals.

In summary, the success of these programs as an integrated whole seems to be based on several factors:

(1) Tribal direction, support and sanction - including the origin of the program ideas and long term objectives.

(2) Formulation of clear cut objectives in terms of needs to be addressed, target populations, and indices to measure progress

(3) Adequate financing from multiple sources (NIMH, other units of HEW, State CMHC, LEAA, IHS, BIA, and tribal funds)

(4) Competent staffs - both external expertise hired and training of local personnel

(5) Careful attention to inter-agency coordination

It would appear that many programs have most of the latter four characteristics and founder for lack of the first. The Warm Springs tribe had nearly thirty years to prepare to undertake the complex mental health programs during which they gained control of the economic factors which are often advanced as a counter explanation for the stress and individual and family disorganization present. While it may not take other tribes this long before mounting an attack, many times the pressure to turn over control to a tribe is a guarantee of failure when the tribe is not ready or for many reasons not willing to take the other factors into account. Equally self-defeating have been efforts over the last hundred years to promote programs for the tribe's own good, without their understanding, without relating them to tribal traditions, and without their readiness and choice of the goals of the professionals.

VII. PORTLAND AREA SUMMARY

A. Achievements

1. A gradually expanding staff which has increased from three professionals in 1969 to 20 MH budgetted positions, and 4 SS budgetted positions in the Spring of 1974. 13 of these staff are Indian Mental Health Workers serving mostly on their own reservations. Two of these are engaged in training which can equip them to join the ranks of the professionals; an informal career lattice beginning with CHR's seems to function at the paraprofessional levels.

2. A well thought out model for delivering consultation services to Indian communities and IHS Service Unit staffs. This model was developed and tested on one reservation and then applied with modifications to the 12 places now receiving Mental Health Services.

3. Coordination with the Social Services Branch takes place where appropriate at the Service Unit and Area Office level.

4. Arrangements to provide Mental Health Program experience in the field for medical students and Residents have remained viable in two of the State University Schools of Medicine and have proved to be of mutual benefit to IHS, the tribes involved, and the training programs.

5. Epidemiological studies of one reservation and a careful analysis of data relating to suicide in the Indian populations in this and other areas.

6. Careful self-observation and analysis of cases seen in consultation, as well as of record usage problems has contributed to the development of an IHS wide form for recording case contacts in terms of problems presented and action taken.

7. A number of special projects, based on coordinating professional expertise and tribal implementation and direction. Among these are the following:

a. The Holding Facility and Suicide Prevention program at Fort Hall.

b. The Tribal Health program at Warm Springs.

c. The Chemawa Boarding School Alcoholism Program

8. Coordination and collaboration with non federal resources such as the following:

a. Two community Mental Health Centers (Eastern Oregon and Pocatello Idaho)

b. Sundown M and SWARF Alcohol Treatment Facilities

9. Development of the only direct service program at the IHS unit based in the USPHS Hospital in Seattle.

10. Development of contracts for mental health care to supplement services provided and to support staff with clinical back-up services to a greater extent than can be provided by Area Office staff.

11. Activity on the part of many staff at a high level of input with national and regional organizations sharing concerns for Mental Health of American Indians.

12. An impressive publication record, particularly on the part of Area office staff.

13. Morale seems good as evidenced by low turnover and a sense of relatively free communication between Area and Service Unit levels within IHS.

B. Problems Yet to be Solved

1. As the program proceeds through natural growth to achieve visibility and credibility to increasing segments of Indian populations and to more IHS personnel, it taxes the physical strengths and time resources of the central office staff to provide the necessary consultation and senior clinical expertise. The transition toward a decentralized program is causing growing pains.

2. The consultation model that has been developed works most effectively when tribal groups are fairly cohesive and have well established processes for mobilizing decision making, and communicating both internally and externally. It does not appear to have alternative modes for interacting with less well organized communities or those where more than one faction or point of view is prominent.

3. Perhaps related to these two problems (the constraints placed by time and energy limitations placed on centralized area office consultants and diffidence about involvement in tribal decision making), is a sense of separation between professionals and the Indian people on many reservations. This distancing ranges form lack of personal acquaintance with members of Tribal Committees to a lack of familiarity with details of customs, conditions, and even contemporary events. There is apt to be little participation by IHS staff in Indian dancing or games, or sports and either under or over appreciation of the importance of these events. There is a heavy reliance on the Mental Health Worker to forge the links between local traditions and factions, and an almost overt policy requiring non-Indian professionals to remain detached.

This is a difficult phenomenon t o document and describe. Probably it stems form the medical aspects of the consultation model, which carry with them an attitude of detachment from emotional involvement and a heightened

awareness of the confidential nature of many observations and much shared information. In community mental health settings these phenomena affect interactions with social units in much the same way as in individual clinical work they affect interactions with patients outside the office .

These observations suggest that the intimate collaborative model first presented by Dr. Pattison has evolved into a pattern which at its best is like the third alternative he mentions of mutual respectful consultation and tends at other times to be more like his first alternative, separate parallel activity and difficulty in seeing viable alternatives bridging between divergent world views. While dissonant in detail from the model presented in "The Anatomy of Consultation", this is a respectable and even an efficient model, given the circumstances of only periodic visits of experts from a distance. As decentralization progresses it needs to be explicitly examined and possible stated more clearly in the orientation of personnel and in presenting options to the Indian community.

4. As in most Areas, there is a high degreee of dependence on case consultations as a vehicle of contact with tribal, and external resources. While this results in contact with many agencies it produces regular scheduled interactions for only a small percentage.

5. Those programs that provide the subject matter for published articles are described in detail but there is a paucity of documentation for other programs or of general reports at the Area Service Unit level. To some extent this may be mitigated by the automated case contact record system which will provide more complete clinical case reporting. However this raw data will not in itself eliminate the reluctance to document and describe ordinary programs or situational problems and follow-up studies

with the same care and completeness as has been applied to recording successes.

In stating this as a problem it should be noted that the defined focus required for producing publications has made an outstanding contribution both within the Portland Area and to collegues at a national and international level. It is also recognized that official reports need to be phrased with caution and an eye to their public relations impact. These factors are atpresent outweighing those which promote a more general recording of explicit goals, processes, and progress at a day to day level. This, like decentralization, is probably a developmental stage, and has not as yet reached a crisis point.

6. There has been a very small over all percentage of turnover among Mental Health Programs Personnel. Those who have moved either through transfer within IHS or to new duties outside IHS tend to remain in close contact with staff who remain. This is on the one hand supportive andprovides continuity of program development. On the other hand one wonders if the process is not a little like cultivating shrubbery but being reluctant to utilize pruning shears. If the separated staff were established as one might use pruned material as cuttings planted at some distance from the original, then perhaps the sense of loss would be lessened, and both could flourish.